METHODS OF PROVIDING REHABILITATION SERVICES TO OLDER BLIND PERSONS

Project No. 30-P-65005/8-01

Submitted by

Ronald A. Landwehr
Project Coordinator

Kenneth H. Hutcheson
Program Director
Division of Rehabilitation
Colorado Department of Social Services

PRINT
IAB 1286

PRINT
371.911
M
Copy 1

METHODS OF PROVIDING REHABILITATION SERVICE TO OLDER BLIND PERSONS

PRINT
371.911
M
METHODS OF PROVIDING REHABILITATION SERVICE TO OLDER BLIND PERSONS
c n.d.
Copy 1
Becky Wilke Feb 6, 1980
MAR 1 3 1980

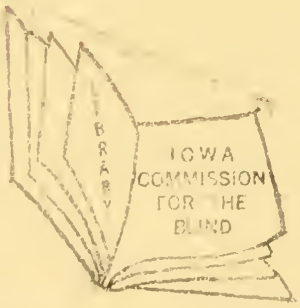


TABLE OF CONTENTS

Chapter		Page
I	Introduction and Objectives.	1
II	State of the Art	4
III	Methods and Findings	7
	Outreach and Referral	7
	Eligibility	7
	Refusal of Services	8
	Special Efforts	9
	Active Client Services	16
IV	Summary and Conclusions	34
	References	
	Appendices	

ACKNOWLEDGEMENTS

Many individuals were involved in contributing to the success of this project. The Colorado State Services for the Visually Impaired extends its sincere appreciation to all persons and organizations who gave their time and efforts. Special recognition is given to those who contributed greatly to the continued success of services to the aging blind in a statewide endeavor.

Mrs. C. B. Wood, Coordinator, and Volunteers
Weld County Visual Awareness Program

Mrs. Marjorie Woodward, Coordinator
"Those Who Care"

Mrs. Charlotte Kanode and Mrs. Adelle Schell
Co-coordinators, and Volunteers
Larimer County Visual Awareness Program

Mrs. Guidotta Bates, Chairperson
Morgan County Council on Aging

Dr. Grace Napier
University of Northern Colorado
Special Education of the
Visual Handicapped

Dr. Raymond Hull, Chairperson
University of Northern Colorado
Communication Disorders

Mr. Stephen Hey

Dr. Mary Frietag, O.D.

Dr. Robert Siblerud, O.D.
and the Tri-County Optometric Society

Dr. John Welch, M.D.
and Associates

Dr. John Adams, M.D.

Dr. Mylan Van New Kirk, M.D.

Dr. Joseph Haefeli, O.D.
and Associates

Digitized by the Internet Archive
in 2012 with funding from
National Federation of the Blind (NFB)

http://archive.org/details/methodsofprovidi00rona

LIST OF APPENDICES

Appendix

A Tables

1. Statuses of Referrals
2. Visual Screening Results Independent Living Geriatrics
3. Visual Screening Results Health Care Facilities
4. Source of Support
5. Other Physical Disorders
6. Services Provided
7. Case Service Expenditures

B Visual Awareness Program Materials

C Mobile Unit: Designs

D In-service Training Materials

E Forms Utilized by Project Staff

CHAPTER I

INTRODUCTION AND OBJECTIVES

By authority of Section 304(b)(1) of the Rehabilitation Act of 1973, the Colorado Division of Rehabilitation, Services for the Visually Impaired, received a three-year service grant from the Rehabilitation Services Administration to demonstrate methods of providing services to older blind persons. The initial Project period of the grant was from June 30, 1974, through June 29, 1977. During the final quarter, a three-month extension was approved which allowed the Project to continue until September 30, 1977.

The primary goal of the Project was to utilize a mobile adjustment team and local resource personnel to provide concentrated diagnostic, instructional, counseling, social and recreational services to elderly blind individuals in eleven rural Colorado counties. In the more isolated areas, many of the training services were to be furnished by use of a traveling van equipped with kitchen facilities and other teaching aids. Shortly after the Project's commencement, the catchment area was increased by one county which aligned the target counties with three State Planning areas and three Councils of Government.

The specific objectives of the program were:

1. To provide specialized services in orientation and mobility, communication skills, and personal management techniques to homebound clients who had not participated in rehabilitation activities due to disabling health conditions, attitudes, lack of motivation, or remoteness of home to public and private facilities.

2. To provide intensive counseling, teaching, social and recreational services on an individual and/or group basis in public or private facilities.

3. To train local resource people how to help the aging blind person maintain and develop independence and how to include the individual in available community activities.

Program emphasis was to include:

1. Screening and identifying potential clients. Efforts were to be directed toward identifying cases of blindness in the 55-year-old or older population, provide education in eye care, and make an appropriate referral to an ophthalmologist or optometrist for diagnostic and treatment services.

2. Enhancing the use of vision by assessment with low vision aids. Project funds were to be utilized if local resources were not available.

3. Developing specialized instructional programs according to individual desires, needs, and physical abilities. Clients were to be encouraged to strive for the greatest possible degree of independence. Transportation to and from instructional centers was hopefully to be resolved by use of volunteer groups. Direct intensive services were to include:

   A. Home management with its many phases, including cleaning, laundering, mending and sewing, shopping, kitchen organization, food preparation and cleanup.

   B. Personal care and management of one's self and personal belongings.

   C. Communication skills, including braille and script writing, telephone dialing, talking book materials and other recordings.

   D. Training in arts, crafts and games to rekindle skills and allow for participation with others.

   E. Orientation and mobility, encompassing sighted guide, safety precautions, precane skills and cane travel relative to the desires and abilities of the client.

   F. Group sessions for discussion of common problems which restrict blind persons from becoming involved in social activities. Use was to be made of existing community resources to involve clients in socialization activities.

   G. Recreational services, including working with senior centers, Older American groups, nursing home personnel, families and friends.

4. Small adjustment counseling groups, especially with the newly blind. Family members or persons closely involved with the client were to be encouraged to participate in counseling sessions to develop ways to assist the client in becoming self reliant. Counseling was also to be provided regarding corrective surgery, treatment and use of low vision aids.

5. Information on blindness and use of volunteers. Seminars and in-service training programs were proposed for nursing home personnel, visiting nurses, Social Services caseworkers, senior center personnel, county extension agents, volunteers and other interested service groups. These training programs were also proposed to include local ophthalmologists and optometrists.

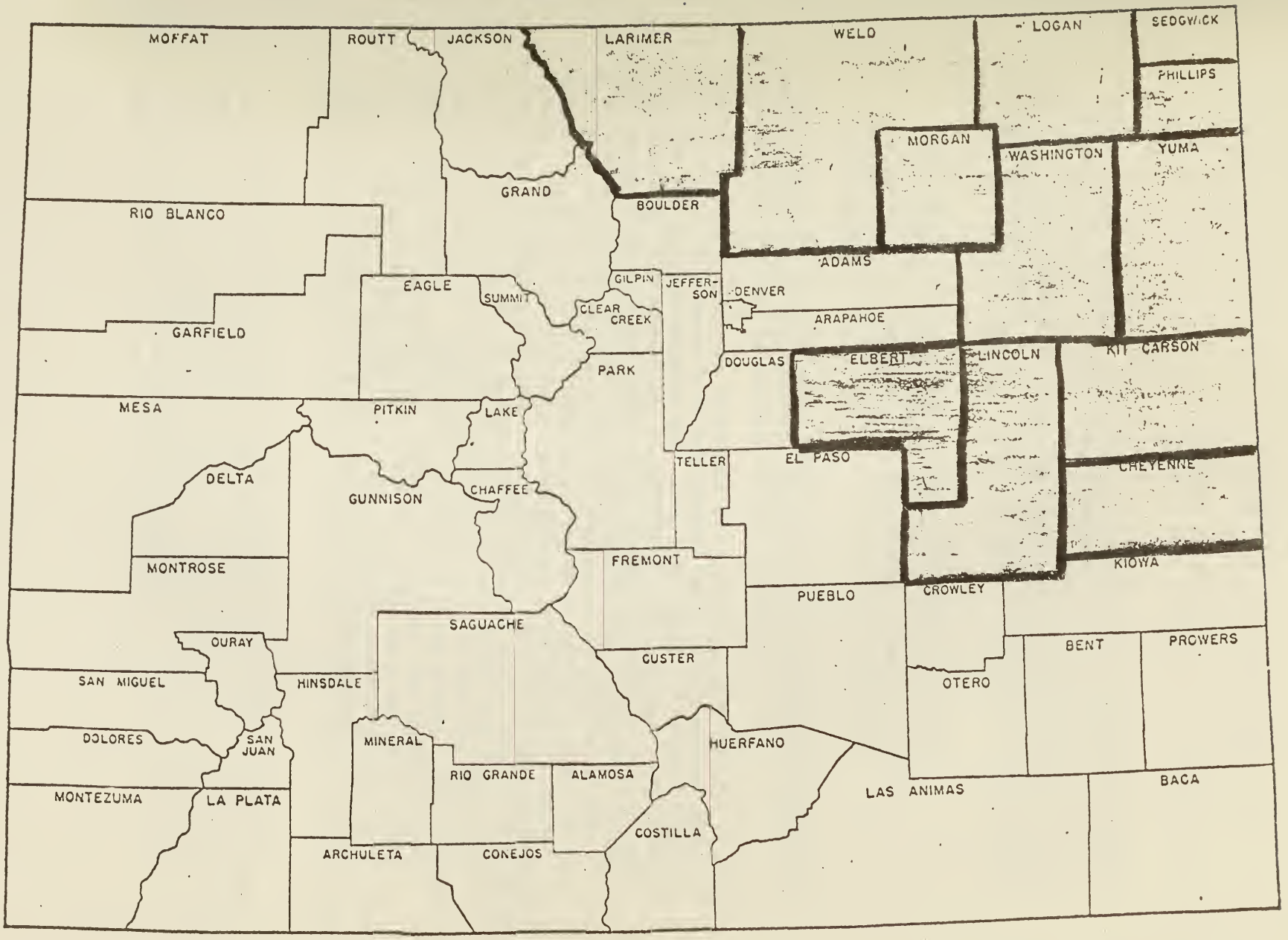
6. Vocational rehabilitation services for interested individuals by making referrals to a counselor of State Services for the Visually Impaired.

Since the thrust of the Project was to demonstrate delivery methods, the collection of personal information and/or research data was to be held to a minimum. Client case service funds were included in the budget to enable individuals on fixed incomes to more fully participate in their rehabilitation program whenever personal and/or local resource funding was not available. The perimeters of such monies were not regulated by a financial needs statement and were allowable for expenditures of diagnostic services, low vision aids, corrective surgery and related health problems, travel, communication aids, or any other service related to an independent living program.

Six staff members were requested and approved in the grant award. The staff included a program coordinator, orientation and mobility specialist, two rehabilitation teacher specialists, a counselor and a clerk stenographer. The counselor's primary duties were related to social work functions; i.e., case finding, family and individual counseling, group counseling and social and recreational activities.

The catchment area selected was approximately the northeast quadrant of the state and consisted of one of the highest population concentrations of any rural section in the state. These twelve counties had a total of 24,247 square miles, consisting of a population of 320,782 persons. There were an estimated 44,128 persons over the age of 60 who lived in the area.

The area historically has been served by one counselor-rehabilitation teacher, a dual functioning staff member from State Services for the Visually Impaired.



COLORADO STATE PLANNING DIVISION

CHAPTER II

STATE OF THE ART

A review of the literature indicates that the problems confronting an aging blind person in a rural area are very complex. Not only does the blindness cause the individual to lose visual contact with his surroundings, but as a part of the aging process he faces the loss of independence and control of his physical environment. A study (AOA Grant #93-P-55904/4-01) done in 1973 on the Spanish-speaking elderly persons in certain communities of Colorado, stated that:

> "The elderly are confronted with broad categories of Issues: Those stemming from his general contact (or lack of it) with the world; those emanating from his need for protection against the world; and, those relating to his ability to enjoy the world about him."

The elderly person is confronted, specifically, with problems in the areas of health, nutrition, income, housing, transportation, socialization, employment, recreation and attitudinal barriers fostered by society.

Although life expectancy has lengthened during the past half century, only one out of five or six elderly is in good general health. With medical advances, long term diseases are becoming more common, resulting in limited activity. Individuals are also susceptible to multiple disabilities involving risks in bone damage, disease of the joints, loss of sight and hearing, loss of teeth and slowing of the central nervous system influencing sensory motor skills. The aging body has often been viewed as a museum of diseases, with some diseases occurring in all individuals and becoming worse with time. As an example, from early in life every individual has arteriosclerosis which progresses and becomes more complicated with age. This is a true representation of the aging process and is the most common cause of death. High blood pressure can also be considered an aging process, and when present long enough can cause complications with the probability of dying. It is in fact the third most common cause of death. Cancer lacks the genuine aging process universally, but the likelihood of incidence does increase with aging. For those who avoid death by these diseases, they are likely to succumb to a variety of bodily insults with cerebral accidents and lung infections occurring most often. These examples are not to portray a dismal picture of aging, but to point out the possible health dilemas of the aging individual which will require rehabilitation services to some degree.

It is predicted that future health care expenses for the elderly will run three and one-half times greater than that of younger persons. Public programs, however, can only be expected to pay two thirds of the costs. The majority of the elderly will receive medicare which will result in personal out-of-the-pocket medical expenses exceeding twice that paid by younger persons. This occurs when one's income is cut drastically by retirement. In fact, one half of all older persons have an income of less than $3000 per annum.

These facts have implications for medical, restorative and rehabilitative services required by the aging blind. They also have implications for delivery of services methods. For unlike youth, many elderly persons cannot be restored to optimal health, yet the adequacy of health care cannot be overlooked or diminished. Health care problems are often compounded because of the lack of medical professionals and facilities.

The aging person residing in a rural area is often isolated. This situation is commonly depicted as having no immediate solution. Twenty-seven percent of all elderly in the United States live in rural communities and represent the only age group presently increasing in numbers nationwide. In assuming the aging blind to be a true cross representation of the elderly population, 29 percent live alone, and 60 percent of those living alone or with relatives are at or near the poverty level. The separative aspects of rural living add to this picture of remoteness and isolation which is further elevated by inadequate income and lack of organized public transportation.

Adequate and well maintained housing has frequently been cited as a special need of the rural aging. Of those who own homes, many are finding themselves to be living in communities where neighbors are gradually moving to cities, resulting in a loss of friends. The rural elderly person has other unique circumstances, among which is the physical distance from social, health care, and community participation events. Regarding employment, the literature has little information concerning the importance of work and vocational needs of the elderly person in rural areas.

The literature, however, is filled with information concerning attitudes and stereotyping of the blind as well as the aging person. Since most elderly blind have become blind in later life, the dual stereotypes of blindness and aging only tend to amplify prejudices. These prejudices range from the belief that the blind are only able to physically perform the simplest of tasks to almost having mystical powers. The preconceptions often contain youth's general distaste for growing old and its inherent qualities of uselessness, exclusion and death. It can be anticipated that the aging blind person will be viewed by many to behave as they "are taught", to think as others expect, and to consequently function at a level far below that which they might otherwise be capable.

The elderly blind is a population which is difficult to reach and serve, much more difficult than the younger blind. The McGuire-Sillen study for the New York Commission found that 16 percent of the aging blind requested that no referral be made for services. Inhibiting factors of acceptance for services identified by the Jewish Guild for the Blind in New York were:

1. Those relating to self concept, including unwillingness or inability to accept visual loss, false hope that vision would improve, and gradual progression in loss of vision.

2. Those relating to personality variables such as apathy, resistance to change and need to retain the dependency role.

The aspect of rurality could, of course, have a pronounced negative influence on individuals accepting services.

Rehabilitation services to this population are seen as a challenge beyond that of current procedures. In this age group there is question as to potential clients' motivation and initiative. An important concern raised by one observer questions the premise that independence is truly the goal of the older person. There is some substantiation that perhaps 20 percent of the elderly tend to be helpless, presumably being taken care of in their own homes.

It has been stressed in the literature that teaching methods espoused for the aging involve family and the utilization of volunteers. Services should be provided in the elderly blind person's own neighborhood or other familiar surroundings. Studies indicate that older blind persons do not wish to relocate, and those who do tend to become increasingly dependent upon others. The direction of any research, it appears, should take into consideration individual life styles in a unique developmental stage--that of growing old.

CHAPTER III

METHODS AND FINDINGS

A. Outreach and Referral

Upon commencement of the Project, client outreach began by contacting those over 55 years of age who were listed on the register of the blind for the catchment area. The list, however, was soon found to be outdated. Since the register of the blind is developed from referrals by numerous sources, the result often is that information is not current regarding change of residence of if individuals are deceased. This lack of information was compounded by the fact that only one rehabilitation counselor previously covered the entire area. Since Federal regulations mandate services to vocationally eligible disabled clients, those people who did not appear to have vocational potential were not contacted. It became more efficient, therefore, to develop and maintain community resources to locate referrals.

In each community persons were located who became primary contacts. Other referral resources, such as county departments of Social Services, aging agencies, civic organizations, facilities and/or volunteers, were developed through in-service training sessions. This proved reasonably successful in locating potential referrals. A disadvantage discovered, however, was that the outreach persons had only a restricted knowledge of their own local communities and surrounding areas, often not knowing persons living in remote rural sections. Many in-service trainings by Project staff resulted in referrals who were not legally blind. Similarly, the staff of health care facilities often did not make appropriate referrals. To more thoroughly outreach communities and receive eligible referrals, two all-volunteer Visual Awareness Programs were developed in the larger populated counties of Weld and Larimer.

B. Eligibility

One of the first problems encountered was that of identifying eligible clients. The criteria of eligibility were:

1. The individual be at least 55 years of age.

2. The individual be legally blind or there be medical evidence that the individual would be legally blind within a reasonable period of time.

3. The person, due to a combination of age and disability, was unlikely to be provided services by the State rehabilitation agency.

The applicant was initially offered ophthalmological services as a diagnostic service from the Project's case services funds to determine eligibility when no such current examinations existed. Individuals without a current record of an ophthalmological examination were provided basic visual screening by staff to determine preliminary eligibility. Determination of visual eligibility was based on ophthalmologists' reports and/or results of those visual screenings conducted by staff.

Many ineligible individuals referred by ophthalmologists and optometrists had seen other eye specialists in the interim period since their last examination and their vision had improved. Public Health nurses referred 15 persons who were ineligible. Since the nurses had no objective access to visual information or programs for checking vision throughout much of the Project's catchment area, it is believed this factor contributed to their making inappropriate referrals.

Approximately 50 percent of the individuals referred by volunteers, who were utilized in teaching and providing transportation, were found to qualify for services. This may have been due in part to the volunteers' knowledge of visual eligibility.

The problem of educating key resource agencies and persons on eligibility requirements plagued the Project throughout its duration. Staff made special efforts to instruct clearly, yet inappropriate referrals continued. That was one reason for the inception of the volunteer Visual Awareness Programs; i.e., not only to effectively outreach referrals, but to utilize a visual screening process to allow for more objectivity in referring individuals.

In total, 98 persons were declared ineligible. All but five were not accepted for services because they were unable to meet the visual criteria. The other five were less than 55 years of age and were referred to the regular field counselor of Services for the Visually Impaired. Of those remaining, twenty individuals were referred for services from other agencies, organizations or professional services.

C. Refusal of Services

At the advent of the Project, staff were encouraged to take along an "important other person" to potentially reduce numbers of persons refusing services. "Important other person" was defined as a person who had a close relationship with the client thereby being instrumental in developing initial trust and confidence in staff as well as the services to be provided.

Goals of the staff were to provide direct services and to fully utilize existing resources when needed. This was done even for those persons who refused to provide necessary documentation for declaration of eligibility. For this reason efforts were initially made to simplify record keeping and to be as flexible as possible in the completion of required forms. Refusal

of services, therefore, was interpreted to mean those persons who would not accept the paperwork and procedures required to become an active client. Of 117 individuals refusing services, 21 were known to be eligible; 11 were likely eligible; 30 were likely not to have been eligible; and the remainder were unknown.

The most common responses for refusing, in order of frequency, were:

1. The person implied being self sufficient, having no needs or problems, or doing all right. This response was given by one-third of those refusing.

2. Individual claimed to have good vision, thereby being ineligible.

3. Not interested.

4. Already had received training.

5. Had sufficient assistance from other persons.

6. Family does everything.

7. Family members refused services for the referral.

8. Did not need help because vision was believed to improve soon.

9. Could not comprehend.

10. Did not want services because it was a Government program.

Of the persons refusing services, 28 did receive referral to other resources and/or received short term services such as help in making application to the Talking Book Program, basic instruction in the use of the Talking Book machines, instruction in various script guides, referral for ophthalmological examinations and basic low vision services.

D. Special Efforts

1. Migrant Outreach

It was realized that there were large numbers of seasonal and migrant workers in certain rural communities. The Project staff were made aware that traditionally these workers travel in entire family units. It was assumed a portion would be elderly and could possibly qualify for services. It became apparent, however, that the Project staff could not effectively find the population who would be legally blind. Consequently efforts were put into developing cooperative programming with the primary agencies serving the migrant worker. Since the Project could provide eye care and rehabilitative services which were not available or for which these agencies had inadequate funding, five such agencies diligently sought out people requiring services.

The results were disappointing because:

a. Only three referrals were made to the Project. Of these three, two were referred to Services for the Visually Impaired because they were younger, and one was eligible for services from the Project.

b. Preliminary efforts were made to tie into the National Migrant Council system. This system has identified relocation patterns of migrant workers and is presently designed to expedite continuous medical care to these individuals wherever they may move. This did not happen because of insufficient numbers of persons to justify use of the Council's computer service.

c. It was found that few of the aging migrant workers travel seasonally with their children. One conclusion was that many of these people do not live beyond the age of 55; consequently, services should be provided at a younger age. In the same vein, special health care facilities have established that the incidence of some diseases such as diabetes (which could have implications of diabetic retinopathy) is much higher in this group than any other group. Generally, little is known about the eye problems of this population.

d. Efforts to disseminate information to these people by conventional written materials or news media were not effective. It is believed dissemination of information to these people should be by personal contact.

2. Volunteer Visual Awareness Programs

In an effort to reach more prospective clients and to assess eligibility, the Visual Awareness Programs were initiated. These were all-volunteer "educational" endeavors. One feature of the Programs was to provide education on the prevention of blindness, especially through a concrete method of visual screening.

In December, 1975, a planning committee developed a training program for volunteers. Weld County was selected as an experimental area for these reasons:

a. Eligible individuals were difficult to identify since this constituted one of the most dense populations of the catchment area.

b. The Project office was located in this county which allowed for good training communication with professional consultants as well as volunteers.

c. Volunteers were more plentiful in that area.

The training program was implemented before the planning committee disbanded. Local ophthalmologists and optometrists were highly supportive and instrumental in setting up such a program. After spending many months locating a coordinator, who was helpful in getting volunteers through her personal knowledge of community persons, the Program began in May, 1976. The initial plan of fully training volunteers before they actively worked in the field was abandoned since many volunteers were reluctant to commit themselves to a comprehensive training program. They did, however, commit themselves to preliminary training in demonstrations and practice in visual screening in conjunction with the Well Oldster's clinics under the auspices of Weld County Health Department. Later they progressed to health care facilities. The comprehensive in-service training was only successful when presented after the volunteers gained experience in visual screening.

The original plan of in-service training for volunteers included:

a. A layman's level of presenting the structure and function of the eye which included a description of eye diseases and visual problems from an ophthalmological point of view.

b. Care and basic repair of eye glasses and how they should fit as presented by an optician.

c. Clarification of the training and applied professional differences of ophthalmologists, optometrists and opticians.

d. Visual screening demonstrations and practice in performing and recording visual screenings.

e. The importance and definition of the role of a volunteer.

f. An introduction to the importance of low vision aids for the older visually impaired person.

g. An exploration of attitudes and beliefs about blind persons.

h. Hearing problems of the older person and how to communicate more effectively.

i. An overview of the eligibility requirements for rehabilitation services and available resources for the older person with visual, medical and rehabilitative needs. It was found to be effective to include presentations by representatives from programs of the Department of Social Services, the Social Security Administration, and the State Division of Rehabilitation.

Training sessions on visual screening were provided by optometrists. The later developed comprehensive training program was provided by relevant professionals. A visual screening record was drawn up by local ophthalmologists and optometrists after it was discovered there

were no appropriate screening records for adults, especially older persons. It should be mentioned that all professionals involved in this training donated their services.

The Visual Awareness Program was also initiated in Larimer County in January, 1977, by two interested individuals. They were able to secure volunteers through affiliates of the Retired Senior Volunteers.

In addition to training volunteers, it was also found to be advantageous to offer training to staff in health care facilities. The training sessions resulted in much greater participation of staff in assisting with visual screenings. In conjunction with the Project staff, volunteers presented eight in-service training sessions at health care facilities on eye care and blindness, as well as four sessions to senior groups. At the termination of the Project, 43 volunteers had been involved in Weld County (plus a Lioness group in one small town). Larimer County had 17 volunteers.

Volunteers participated in distributing literature, showing audio-visual materials on blindness and eye care to aging populations and to staff of health care facilities. In general, they became quite independent in presenting materials to professionals and lay people. (See attachments for visual screening record, procedure and definition.)

The objectives of the screening program were:

a. To identify older persons in independent living situations and in health care facilities who were suffering from vision problems.

b. To directly assist in bringing about eye treatment and care, including transportation and financial assistance for those who might benefit.

c. To appropriately refer older persons for rehabilitative services.

d. To provide information about resources for eye care, rehabilitative services and information about blindness.

e. To demonstrate the effectiveness of utilizing community resources, especially volunteers, in providing ongoing vision screening services and public education.

f. To affect a more general public awareness of visual problems and needs confronting the older population.

By and large the volunteers attempted to follow the methods used by the Preliminary Geriatric Visual Screening Survey of the Utah State Board of Education in 1974. The Snellen Eye Chart was utilized for

distant visual acuity. A twenty-foot visual lane was generally used. A ten-foot lane was utilized for bedridden persons or in facilities which could not accommodate the longer lane. Unlike the referrals of the Utah study, it was determined that referral for eye services should not be based necessarily on severe loss of vision. (See Procedure for Screening the Elderly.)

The examinee was allowed to hold the Snellen Chart at a comfortable distance for reading and results were recorded on that basis. If the person used magnifiers, they were encouraged to bring these to the screening and results were recorded as a final check of adaptive aids facilitation of near visual acuity. All persons having prescription glasses were checked with and without, for near and far vision to hopefully alleviate volunteer errors in judging the glass prescriptions. Snellen E charts and cards were used. When the individual could not comprehend verbal directions for the regular Snellen letter chart, time was spent in training the client to accurately point the direction the "E" was facing. Since emphasis was on accuracy in screening, the test usually took from 15 minutes to over one hour per person. The volunteer who assisted the individual in filling out the questionnaire often was a different person than the one who actually administered the visual screening test. A form was designed which required the signature of the person assisting in completing the form. As a result, volunteers who made errors were readily identified. Training was provided to correct mistakes and prevent other problems.

The judgment for medical eye care referral was not based exclusively on "pass or fail", but also on other factors. These other factors were: time elapsed since the individual's last ophthalmological exam, the present condition of their prescriptive glasses, the individual's own lack of satisfaction of present eye condition, and symptoms expressed.

It was found that best results were achieved with persons living independently by having an experienced volunteer give recommendations regarding his or her screening program. If financial assistance, transportation or help with appointments was required, the volunteer would make the referral to the appropriate resource. Generally the screening program was broken into specific functions and work areas. A given number of volunteers assisted in filling out the questionnaire portion of the visual screening record; while others adjusted and cleaned eye glasses, screened far and near vision, and made recommendations. The coordinator focused on additional individual needs and attempted to make preparations for final disposition. The checking, cleaning and replacement and tightening of frame screws was found to be an extremely important service, especially for nursing home residents. Nursing home staff were provided glass repair kits to continue such services when necessary.

For health care facilities, the screening organization was similar, with efforts being made to minimize the necessity of residents having to move from one location to another. Results were not directly interpreted but rather collected, reviewed with consultation, and recommendations made. The results and recommendations were then discussed with key health care facility staff who knew the residents well. Their recommendations tempered incorrect responses and supported actual commitment towards assisting individuals with final disposition of visual needs.

Screenings were held in a volunteer clearinghouse, Federal housing site projects, health care facilities and Well Oldster settings which directly serve older people who live independently. Assisted by Project staff, the volunteers presented two in-service trainings on visual screening, eye care, and blindness to nursing home staff and the general public. Indicators of their success were the number of screenings conducted, community cooperation, and general receptivity of the health care facilities. In many instances nursing home staff were instrumental in following through in seeing that necessary services were provided. The volunteers became a major source in making appropriate referrals to the Elderly Blind Project.

The Visual Awareness Programs held screenings in a total of 17 locations. Out of the 17, ten were held at screening sites for independent living geriatrics. Three of those locations were in cities, and the others in seven rural areas. The other seven rural screenings were held in health care facilities.

The volunteers screened a total of 142 independent living individuals, of which 74 percent were female and 26 percent were male. Average age of males was slightly higher, with the average age of both sexes being 70.91 years. An attempt was made to calculate the length of time since each individual's last eye examination, but most could not remember when they had their last examination.

Over half of the individuals had symptomatic complaints; the most common being recent changes in vision, seeing specks before the eyes, and frequent pain in the eyes. Since eight of the screening locations were held in cooperation with the Well Oldster's clinics, Public Health nurses agreed to follow up and make appropriate referrals. At the termination of the Project, results and final dispositions of these efforts were not available. This endeavor, however, did contribute to Public Health nurses eventually conducting their own visual screening programs.

The results of two screenings conducted in Federal housing projects were interpreted directly to the individuals, allowing them to make personal decisions as to suggestions regarding further professional services. Almost 12 percent of all persons screened who lived independently were referred to the Project for further services.

At the seven visual screenings held in health care facilities, 379 individuals were screened, of which 67 percent were females. Females were slightly older than the males. The average age of persons screened was 79.4 years of age. These screenings revealed that a lower percent (45 percent) of those screened were dissatisfied with their vision than those living independently. Surprisingly, even though a lower percent were dissatisfied with their vision than those living independently, there was a much higher rate of failure from the screening results (72 percent). Frequently individuals responded as being satisfied with their vision, yet on the other hand, often listed a number of personal eye symptoms or problems. In fact, 60-70 percent did state having symptoms. The more common were: frequent pain in the eyes, recent change of vision, floaters, colors becoming less clear, and blurring vision.

The number of individuals failing near point vision in both eyes, was to reflect the number of individuals who commonly stated a desire to have correction of near point vision rather than distant. Most desired to have more full use of near vision for tasks such as reading, sewing, writing, crocheting, etc. Thirty-four percent were found to fail near vision criterion of 20/60 although the individuals were allowed to adjust the near card at whatever distance would accommodate full use of near vision. Those with severe visual loss often stated the extreme of acceptance or toleration of visual loss, or the desire to see everything better.

As with the independent living older persons, the residents had difficulty in remembering when they had their last eye examination. Coincidentally, nursing homes commonly had no ophthalmological or eye specialist reports on hand for individual residents. To further illustrate the elapsed time since the last examination of those capable of remembering, seven responded they had never had an eye examination, 23 reported having been 5-10 years, 13 reported 10-20 years, two reported 20-30 years, and two over 30 years. Nineteen could only state that it had been a long time ago.

During the Project period the volunteers referred 106 persons who would most likely be determined by specialists to be legally blind or partially sighted. Partially sighted was defined as having 20/100 to 20/200 distant and/or 20/70 or less near visual acuity with the near reading being taken at the most accommodating reading distance for those screened.

Follow up at the termination of the Project was left with health care facility staff. Facility number four (see Table No. 3) had an interesting development. An optometrist donated her time to retinoscope the 24 mentally retarded persons who were incapable of being screened by volunteers. The results and further follow up by ophthalmologists indicated six had cataracts, one received surgery at the end of the Project, two received new glass prescriptions, and two had other visual difficulties.

As in the Utah study, attitudes of staff in a number of nursing homes were of a negative posture. While some nursing home staff followed up well, others did not. In some situations it was observed that staff reflected administrators' negative attitudes and lack of enthusiasm. A number of the private profit-making corporations had internal difficulties which affected staff morale. It was determined that in those situations it was too great a task to have volunteers follow up the visual and related needs of residents with families.

In one nursing home the staff did not assist in following up to see that recommended services were given. As a result the volunteers attempted to bring about these needed services for the residents. The volunteers worked with families of those individuals who were not capable of pursuing services on their own. In many of these cases, the families also were very reluctant to help. These attitudes of family members even more adversely affected the morale of volunteers than attitudes of nursing home personnel.

The screening of individuals presented a concrete method of education, was a source of referrals and was a rewarding experience for volunteers. An example of effective education through practical application was presented in the case of a lady in her eighties who was assisted into the screening room by the director of nursing of one home who stated, "She needs assistance due to some type of imbalance problem." As it turned out, this lady could only finger count at three feet and was not able to accommodate reading the top letter on a near point card with or without glasses. Her problem was not imbalance, but vision. The question becomes: How many other nursing home residents require visual services because staff have attributed their disorders to other health problems?

The full assessment of the volunteers in meeting program objectives requires more time; yet their efforts were a primary ingredient in obtaining funding for a statewide elderly blind program.

E. Active Client Services

1. Methods

One of the most productive areas of the Project was the evaluation and implementation of modes and techniques of providing services. The different modes of providing services were delivering services by the use of a motor home, the use of community facilities, and directly in the homes of clients. Due to the special characteristics and unique needs of the aging blind population, staff found it necessary to develop special techniques in teaching in those situations.

a. Physical Modes of Delivering Services

(1) Motor Home

The original application for the project, "Methods of Providing Services to Older Blind Persons", included a mobile unit to be an essential component in delivering innovative services to clientele. As conceptualized, the van was to be used experimentally as a home teaching evaluation and personal adjustment training unit for those individuals isolated because of multiple disabilities; those living in rural areas where inadequate community facilities existed; and those for whom the unit could provide a transition for greater involvement in the community and whose utilization was to be based on personal choice.

A problem immediately identified was that a service van would be too small and poorly designed to provide home teaching services. A mobile home, therefore, became the most logical choice. The categorized budget of $13,245 allowed for purchase from a small selection of the most economical motor homes.

A 27-foot Winnebago Motor Inn model was selected for the Project. Approximately eight feet of the rear interior section was factory equipped with a stove, sink, counter, refrigerator, closet, furnace and storage space. (See diagram.) The remaining forward space was available for custom installations. Identical cabinets were built over both wheel wells. They were designed primarily for training in kitchen organization and food preparation. Florescent lights were installed over both cabinets. Space in drawers and cabinets was planned for vertical or horizontal storage. A counter was built which ran along the left side with the forward three feet accommodating a removable top which provided access to a dropped shelf. This held a portable sewing machine and/or other equipment at a height comfortable to clients. The remaining desk was equipped with drawers beneath the top. Overhead storage cabinets ran the length of the desk. Two double and one single swivel lights were mounted above the counter. The right front side was furnished with a bench seat under which there were two drop lock drawers with vertical and horizontal dividers. A double swivel light was mounted above the bench. (See specifications.)

After a week and a half orientation of new staff, the Project began providing client services the second week of January, 1975. The motor unit was not available for use for approximately two months. During this interim, services were provided entirely in clients' homes. The plan was to target services in distant rural areas which could be adapted to utilization of the training unit. On receipt of the unit, however, many clients

were reluctant to change service modalities. Three clients who agreed to change methods were later provided services again in their homes. It became apparent that given a choice many clients would select in-home convenience. In attempts to control this, two counties, Cheyenne and Kit Carson, were publicized as being serviced only by a mobile unit. Services were provided, however, to those individuals too physically incapacitated to benefit from services outside their homes. In addition, the unit was also used as a public relations and community in-service training center. The latter goals were attempted in almost all counties throughout the Project period. Experience later dictated more flexible means of providing public relations and community training; namely, larger community facilities.

Services provided via the vehicle were generally of five categories: (1) direct client services; (2) intensive training to agencies and organizations; (3) public awareness and public relations; (4) short-term training of agencies, organizations and general community; and, (5) delivery of other professional services.

The most frequent staff efforts in the unit were directed to providing home teaching services. These primarily included evaluation and training in low vision aids and listening devices, braille, typing, techniques and aids for homemaking and home management, handwriting skills and aids, mending, crafts, personal management skills and counseling. Individualized teaching as well as group teaching was attempted. Also social groups were briefly attempted. Mention is made of an isolated nursing home resident for whom the mobile unit offered an opportunity for evaluating skills for a more independent life outside the nursing home.

Even though the motor home was often parked near a community building such as Senior Citizens or a local church, it did not facilitate the teaching of orientation and mobility. It was a foreign environment, much too restrictive for such purposes, especially for clients who required training in their own home and/or neighborhood.

Limited space dictated limited numbers. Generally only four or five individuals could receive intensive in-service training. Only a portion of the in-services could be practically offered. A beneficial aspect was that of demonstrating special aids and appliances which otherwise would have had to be carried and set up at a facility. Also, the unit was extremely useful as a newsworthy item for both television and the newspapers.

The final area of applicability was taking other professional services to rural areas where specialized services were almost non-existent. A specialist in optometric low vision furnished services to one county with successful results. Also tentative plans were made to deliver much needed audiological services to

areas where they were not available or where clients refused to travel long distances for such services. Planning included a volunteer visual awareness program for migrant and seasonal workers. The purpose would have been to distribute prevention of blindness education material and provide visual screening. These plans did not materialize. The mobile unit was transferred within the Division before an effort was made to deliver audiological services. The visual screening for Spanish-speaking people was not implemented due to a potential duplication of services being provided by a health care center.

The measurement of the mobile unit's success as a "training center" was not in quantitative numbers, but rather it was evaluated for its practical value in providing services. Efforts were made to show its assets and limitations and to highlight recommendations for future endeavors of a similar type. Much of what has been discovered can readily apply to the aging, especially the aging handicapped.

It is difficult to depict truly unique aspects of serving the aging blind by this method since the positive components of services can also be provided by other means. Consequently the best aspects of the unit were: (1) Its use as a public relations trademark. It often created an enthusiasm for townfolk and news media alike. The enthusiasm, however, rapdily dissipated when it was realized the unit's applied value was in working with clients. (2) The mobile unit's best direct client application was as a homemaking management evaluation and training center for visually impaired nursing home residents. Those individuals, however, were special cases where training facilities were not convenient. (3) Among the most successful uses of the unit was furnishing optometric low vision services to clients. Without doubt, full exploration of different kinds of services such as audiological exams would have brought about other effective uses.

The problems experienced with this method were found to exceed any direct and/or unique contributions as a service delivery system. These problems are in the areas of architectural barriers, travel, maintenance, client-related and staff-related factors.

Architectural Barriers

The first architectural barriers noted were the front and rear steps. The bottom steps slid from an undercarriage bracket. When these steps were pulled out, the accessibility barriers were: (a) The bottom steps were in excess of 12 inches from level ground and shifted under weight-bearing to contribute significantly to personal instability. This was often compounded in rural areas where parking areas were unpaved, often unevenly contoured. Clientele as well as many of the visitors and in-service trainees required physical assistance in entering and leaving the motor unit. (b) The factory installed

handgrips provided inadequate support for older persons lacking the strength required to pull themselves up the steps. (c) The last steps in the stairwells, which constituted the highest steps, were virtually impossible for most older persons to navigate. (d) On exiting, the steep steps evoked fear and were perhaps the most unsafe aspect of all. (e) On both ascent and descent, small treads added to insecurity. The treads became more hazardous in bad weather.

By design the unit provided limited access to the ambulatory handicapped and totally inaccessible to wheelchair clients. An orthopedic step with a supportive handle was purchased to accommodate the problem of the bottom step height. The step, however, also lacked stability on uneven ground surfaces. To fully rectify the entrance and exit barriers, major modifications were necessary. In investigating the practicality of a ramp, it was found that its weight and the length required to accommodate a satisfactory walking angle made it impractical. Portable steps were found to be even more unsteady than the existing equipment. The best potential solution was the lift-type platform. After considering its expense in relationship to other existing problems, the cost was found to be prohibitive.

The second barrier was the rear kitchen area. A working space of little more than two feet was provided for the stove. It was quickly discovered that the stove could not be used for evaluating and training the elderly. A protruding cover over the rear step encasement created unsure and cumbersome footing. The rear sink and cabinet space were also crowded into a two and one-half foot working space which made it almost impossible to work. The refrigerator, likewise, was difficult to use.

The overhead cabinets were too high for clients to reach. The unit's door latches did not secure the doors in travel, largely due to being constructed of thicker wood which increased the weight of the doors. Ceiling mounted magnets were insufficient in holding upswinging doors shut, resulting in dropping doors.

The barriers found in this standard unit restricted the types of services which could be provided. Staff preferred rigidly scheduled individual lessons away from the unit as opposed to group activities in the unit. Also, advantages were found in arranging in-service training in more spacious community facilities.

Problems of Travel

Many problems were experienced in driving and parking the unit. Although staff practiced operating the vehicle on the straight highways of eastern Colorado, apprehensions persisted because of the unit's size. Fortunately, two female staff members had previous experience in driving large vehicles. During planning, it is important to note who is to operate such a large unit. Fear can affect the results of any such project.

The lack of adequate parking facilities frequently existed in smaller towns. A level position was a distinctive need. Older persons often displayed a lack of balance on the slightest parking slope.

Problems with Maintenance

The mobile unit required considerably more regular maintenance than professional persons generally are capable of providing on an ongoing basis. A primary example was the water system. In cold weather, the tap water and toilet facility required antifreeze. Potable antifreeze was the only suitable additive for the tap water. The system required regular flushes to prevent the taste of plastic. Also the water system affected sewage disposal. Staff had to deal with the maintenance and/or problems with the system.

The stove, refrigerator and furnace used propane. This needed to be monitored and was best accomplished by individual assignment. Originally a male counselor was given this task. Later on an all female staff had to handle the assignment which did not prove to be successful.

On most occasions the furnace or the air conditioner, which were furnished electrical input from an auxiliary generating motor, were in operation. All three units emitted noise which severely hindered communications, especially with those elderly individuals having hearing impairments. Interference increased as the numbers of persons in the unit increased.

The additional custom-wired lighting also appeared to be the prime cause of occasionally overloading the generating capacity of the auxiliary engine. This had a direct relationship to limiting the number of simultaneous activities involving the use of electrical supply.

Beyond general maintenance, there were a number of repairs made. Many of them were within the first year. Some of the major and reoccurring problems were: brake and auxiliary engine repairs, speedometer problems, replacement of the regulator, leaking water pipes, changes and adjustments of custom equipment, repetitive battery charges, and general fixture malfunctions. As with all known mobile units, there were two separate warranties: one for the chassis (truck frame, chassis, drive and engine), and one for the basic unit and its auxiliary equipment. The nearest dealer was in Denver approximately sixty miles away. The custom features were the responsibility of a cabinet shop which was also in Denver. The repairs not only resulted in considerable downtime in use, but also required staff time in taking the unit to the dealer.

Client Factors

In 1975, estimates of the most severely disabled persons in the United States were that 47 percent of all severely non-institutionalized handicapped were 65 years of age and over. The most frequent disabilities were musculoskeletal and cardiovascular.[1] These conditions often cause difficulties in walking. Many such aging individuals require supportive aids. This factor was one reason for the lack of utilization of the unit by many older persons. The hardships encountered in venturing out of the home, especially under adverse weather conditions, hindered most of the elderly. Weather conditions were often cold and windy. High winds are commonplace in eastern Colorado throughout the year. It intimidated clients' travel out-of-doors and caused instability to the unit itself.

Also because of many individuals' inability to transfer learned skills, it was necessary to follow up approximately 50 percent of all individuals served in the unit with instructions in the home. One such person was found to have no transferrable skills. An advantage of instruction in the home was actual "demonstrated" needs and having personal appliances available to perform activities of daily living. In effect actions were much louder than words. Individual needs were most often identified by clients' activities in their home. It would appear that any instructional program for the aging should be based on individual needs rather than using an established curriculum.

Another disadvantage to mobile services is that many aging people did not wish to leave home. They felt most secure in familiar surroundings which affected their receptiveness to services. Also some did not want the stigma of "blindness" which was associated with the mobile unit.

Staff Factors

As a result of the many problems experienced with the van, staff became gradually resistant and less innovative in personal application of the unit. Eventually they became convinced that services could be most effectively provided in the individual's home environment.

[1] Urban Institute, Executive Summary of the Comprehensive Needs Study of Individuals with the Most Severe Handicaps, 2100 M Street, N.W., Washington, D.C.: Urban Institute, June, 1975, pp. 8-9.

Indications of Cost and Relative Benefit

During the two years of using the unit, it averaged 5.9 miles per gallon in a geographical area which varies between flat land to rolling hills. The cost of repair and maintenance cannot be calculated since warranties covered most repairs. Hopefully, repairs would decrease over those incurred in the first year.

Data was insufficient to assess the actual staff costs incurred in use of the vehicle. Four points, however, were identified in estimating costs:

(a) Staff downtime occurred because of the general maintenance and time involved in taking the mobile unit for repairs. The operation of such a mechanically sophisticated vehicle by staff with little mechanical knowledge will likely take its toll in repair costs over an extended period of time.

(b) Client cancellations of appointments contributed to a downtime period of not providing services approximately six percent of staff time.

(c) Obtaining dependable transportation for clients to come to the unit proved to be time consuming for staff.

(d) Because clients in rural areas were so spread out geographically, staff experienced difficulty in providing well coordinated teaching programs. The mobile unit limited independent staff travel which detracted from direct service time.

(2) Use of Community Facilities

Special efforts were made by a home teacher and the orientation and mobility specialist to serve clients in existing community resources in two of the lesser populated counties. Facilities utilized were a community center for a Federal Housing Authority, a Senior Citizens building and a church. Kitchen facilities were required for rehabilitation teaching. The facilities were only available when these organizations had no planned activity.

A total of five persons were evaluated and trained in the three facilities. The utilization of kitchen facilities did provide for specific evaluation of the individual in preparing and cooking of food. Other than these skills there were no special effects or advantages of such a method of delivering services.

Definite problems occurred:

(a) Transportation had to be arranged by staff. Once developed, there were ongoing problems in dependable travel. Cancellations were more of a problem, resulting in staff downtime. Although not entirely dependable, families proved to be the best source of transportation.

(b) Most facilities were poorly adapted as training centers. Among the most common problems were: poor lighting, inadequate equipment, and unpredictable interruptions by others. There were also ongoing disadvantages to clients being taught in unfamiliar settings. These surroundings did not provide the home teacher with a good grasp of the individual's own concrete needs within his or her own home. It was found that this clientele benefitted more by being evaluated and trained on their own appliances and household equipment.

(c) Group teaching was ineffective. There were too many individual differences among clients which required various methods of teaching.

(d) Orientation and mobility was found to be most useful in teaching the client in familiar environments or in those areas where he desired to travel.

(e) Community facilities did not prove to facilitate socialization. Generally the individuals did not become involved in additional social functions. They often did not even desire these activities.

(3) Services in Clients' Homes

The most desired modality of serving the independent living client was within his own home. For the home teacher this was a setting of fewer interruptions and of concrete evaluation and training. The client was assessed in familiar settings with his own household equipment. The home teachers more readily identified real problems within the home. The generalization and adaptability of skills from an unfamiliar environment to the home often proved difficult and time wasting. Only the more mentally alert and physically capable (which was a minority of the aging blind in this project) could make such a transition smoothly. For this same reason, the orientation and mobility instructor preferred teaching in the client's familiar surroundings. Most often outside travel was route learning. Persons were seldom provided the full range of mobility services. Typically those who did receive full mobility services were usually 55 to 65 years of age.

b. Staff Techniques of Delivering Services

Services to rural areas were initially provided on a team approach basis. Equitable caseloads among staff, however, was an ongoing problem. This was eventually resolved by having staff travel and schedule independently. Consequently travel costs increased. Cost benefits lay between the disadvantages of unequal staff downtime and client caseloads in the team approach as opposed to vastly increased per diem and travel costs in the individualized and coordinated staff scheduling approach. The team approach was one of the major drawbacks of the motor home with its additional factors of rigid scheduling and increased cancellations of appointments. This left staff in a position of having no other dependable transportation to facilitate the full use of their time.

The best method of operation was to target service in specific counties in the following manner:

(1) Contact all community resources and news media regarding the program.

(2) Develop community persons to help with finding eligible clients.

(3) Interview all referrals to determine their eligibility and/or acceptance of services.

(4) Provide direct services to qualified applicants.

The aforementioned methods greatly reduced the referral status time because of concentration in specific areas. It was also found to be effective to schedule the provision of services around clients' other interests and activities. They were more likely to accept services which did not interfere with every day living. Clients were generally seen from one to three times per week, with the duration of each teaching session being individualized to the client's endurance and time preference. Typical sessions lasted one hour. Best results were achieved when sessions were frequent, but travel time limited this, especially in the more remote areas.

A final result of the Project was that the average length of time individuals were in referral status was 2.8 months. Fifty-seven percent became active clients within one month. The average active service time per client was 5.4 months.

c. In-service Training by Project Staff

A total of 72 in-service training sessions were offered by Project staff, not including the ten jointly sponsored with volunteers in the Visual Awareness Programs. Sixty-six of those sessions were short-term training and informational programs of about one hour's

duration. These were offered to organizations and groups such as Senior Citizens, Meals on Wheels, local Social Services departments, university classes, nursing homes, home extension agents, housing authorities, Councils on Government, rehabilitation centers, women's clubs, health centers, councils on aging, the Migrant Council, Chambers of Commerce, Lions Clubs, Public Health Departments, the Ministerial Alliance, hospitals, volunteers and other agencies working in some capacity with the aging and/or aging blind. Information presented at each in-service was tailored to meet the needs of the participants.

The primary purpose of the in-service sessions was to familiarize the organizations and groups with techniques, services, resources, and a better understanding of the psychological and medical aspects of the aging blind as well as knowledge of available aids and appliances. Whenever possible, staff used various demonstrations in these sessions. For example, demonstration and practice under the blindfold was exceptionally well received. Information derived from written follow-up questionnaires supported this. The questionnaires also confirmed that having a blind person present his personal experiences proved to be most valuable.

There were six intensive in-service trainings. Two were offered to county departments of Social Services, two to nursing homes' staff, one to Home Helps, and one for all agencies throughout the twelve counties. The first five in-service trainings followed the format of the attached sample outline in the appendices.

The sixth in-service training session was a comprehensive workshop entitled "A Multidisciplinary Approach in Working with the Aging Visually Impaired", co-sponsored by the American Foundation for the Blind, University of Northern Colorado and the Project. It was based on the premise that:

(1) The aging blind can be best served via many agencies of multi-disciplinary specialization.

(2) The aging blind are for the most part multihandicapped.

(3) The speakers selected offered an opportunity for learning seldom available in rural areas.

The workshop had an attendance of 129 persons. All rated the workshop from good to excellent which confirmed its usefulness. The presentation on hearing impairment was most frequently mentioned as the most valuable presentation. (See attached agenda. Attached also are samples of case histories used in problem solving training.)

d. Special Nursing Home Efforts

Realizing that the primary services provided to nursing homes had been in-service training sessions and direct services to a few blind residents, the rehabilitation counselor and a home teacher made a special effort to implement more comprehensive services to one nursing home towards the end of the Project. The two main objectives were to:

(1) Provide an opportunity for social contact for visually impaired residents.

(2) Provide rehabilitation teaching services to blind residents in groups. All previous efforts had been to teach blind residents individually.

The endeavor was to have these residents share their ideas and feelings about visual impairment. It was soon found, however, that most did not consider their blindness as being a significant disability. They were concerned more with the severe limitations of other disabilities such as arthritis, stroke and poor hearing. These clients commonly expressed that the group sessions did not provide a meaningful socialization and that there were already too many daily social activities in the health care facility. They tended to see the session as one more activity they were forced to attend.

Due to these negative attitudes towards a social group, the staff changed their focus to that of demonstrating methods of group rehabilitation teaching. It was quickly discovered that most of the participants would not express their needs in a group setting. The needs which were expressed were not necessarily common to all members of the group. Thus it was difficult to maintain the interest of the entire group in teaching. Another problem encountered by the staff members was the high incidence of short attention spans and hearing impairments.

Many of the clients had very limited mobility which meant that the nursing home staff had to assist them to the meetings. The majority of the staff resented spending their time getting the patients ready or helping them to the meeting areas. Even those few nursing home staff members who originally cooperated eventually felt they were wasting their time.

The findings of these two Project staff members further confirmed that one-to-one teaching is much more effective than group teaching with the blind nursing home resident population. Not only were they able to hear and understand better in individualized teaching sessions, but they were also more receptive and cooperative. Ideas which were previously rejected by all members in the group teaching were much more readily accepted by individuals in the one-to-one

teaching sessions. The scheduling of individual sessions also was a more flexible means of working around the daily routines of the residents. It was also found that residents had more stamina for longer individual training sessions than they did for groups.

e. Additional Volunteer Programs

This section is devoted to efforts of volunteers beyond that of the Visual Awareness Programs.

In addition to volunteer assistance through other agencies, especially Retired Senior Volunteer programs and Councils on Aging, Project staff utilized the services of twelve specifically designated volunteers in four of the outlying counties and two in Weld County. Their functions included referral, motivating individuals for services, socialization and visitation, rehabilitation teaching, transportation, crafts and recording for clients. These volunteers served a total of 13 clients on an as-needed basis. There was no formal or organized training program for this group of volunteers.

An organized program was started in the city of Greeley by a volunteer who was instrumental in developing one of the more successful uses of community resources. In coordination with the Project, she, with two other volunteers, implemented a special social group which was called "Those Who Care". A large health care center provided meeting space for the group and also provided lunches, refreshments, professional staff assistance, hostesses, drivers and transportation via their buses for the handicapped.

The social group consisted of Project clients living within the Greeley area, older visually impaired persons from several health care facilities and other blind persons living independently. The group began by meeting approximately every two weeks and, later, monthly. Participants were encouraged to develop the agenda with the guidance of the volunteers. Activities included luncheon speakers, live music, travel films, etc. A more successful planned program was one at which members were each asked to introduce and speak about themselves. The group continued successfully through the end of the Project as a unique socialization opportunity. It also became the basis for the development of a new chapter of an organized group for the blind in Greeley.

A well-trained blind volunteer was used in a mini-demonstrative program which attempted to outreach referrals who had previously refused services. The goal was to provide teaching and related services by a peer which would hopefully result in that person eventually accepting services from Project staff. The volunteer contacted six persons whom she personally knew and who had refused services from staff. She was successful with one individual. Some of her accomplishments with this person were that she assisted in becoming more involved in social life within the community, helped her with leisure time activities, and communication skills.

The Project ended before it could be determined whether or not the other five would become receptive to her. This concept deserves further exploration in innovative programming; i.e., having well trained peer rehabilitation teachers outreach and provide services to the aging blind population.

2. Client Findings

a. Statistical Data

The Project served a total of 166 active clients. The number of females and males were 104 and 62 respectively. Their ages ranged from 55 to 98. Only 11 percent of the population was under 65 years of age, with the same percentage being over 90 years of age. Seventy-eight percent were between the ages of 65 and 90. All but one individual over age 90 were females. The primary mode grouping was 80 to 84 years of age. The mean age of females was 77.9 and of males 76.9 years. Of the clients served, 153 were Caucasian, 12 were Spanish surnamed, and one individual was an Indian.

Educational levels varied greatly. Seven percent of the clients had never received education in a formalized system. Twenty-one percent had received from one to seven years of education. Twenty-eight percent had graduated from grade school (eight years of education). Six percent had received some high school education, while nineteen percent completed high school, and a similar percent had received some college and/or graduated.

The majority of clients were dependent in full or part on Social Security retirement or widows' benefits for their support. Fifty-eight of the clients would not divulge the amount of their income. Of those 108 reporting, however, their average income was $259 per month.

The marital status of females showed that 67 were widowed, 25 married, 8 single, 2 separated, and 2 divorced. The marital status of males reflected 33 married, 18 widowed, 9 single, 2 separated and none divorced.

Very little has been written in the literature concerning visual disorders of the aging. Some of the writings, however, cite that blindness in the 55 and over age group comprise 55 to perhaps 68 percent of the total blind population. Statistical studies only touched upon eye diseases in this age group.

It was found in the Project that 88 percent of the clients had a primary diagnosis falling within seven visual disorders. In order of frequency they were: macular degeneration, 59; cataracts, 33; glaucoma, 21; diabetic retinopathy, 14; retinal deterioration, 7; retinal detachment, 6; and optic nerve atrophy, 6. The remaining

twelve percent of visual disorders were comprised of classifications of retinitis pigmentosa, choroiditis, keratitis, accidents, leukemic retinopathy and corneal disintegration.

It is doubtful whether accurate statistics on eye diseases can presently be collected on the aging population. Such information could only be accurately compiled by eye care specialists. It was the experience of the Project staff that:

(1) Some eye care specialists' attitudes towards the older person's diseases discourages visual care and prolonged monetary expenditure.

(2) Many individuals resign themselves to live with their visual disability without ongoing medical care.

(3) The majority of eye diseases have limited treatment benefits and relatively no cure.

(4) Some eye specialists do not care to work with aging persons in general, especially those in nursing homes.

It was not uncommon to see older persons with eye diseases and blindness who had not been to an eye care practitioner for five, ten and even more years. The Project also was unable to collect client data on the average age of the occurrence of blindness and could only determine that in most instances, blindness for this population does occur in later life.

The question arose in State of the Art as to what might be the implications of other severe disabilities present in the aging blind population. Findings were that 88 percent (147) of the Project's clients were suffering from other disabilities which supported the concept of this population being largely multi-disabled. These were seen as other limiting factors; in fact, in some cases more debilitating than blindness itself.

Approximately 50 percent of the individuals lived alone; the remainder lived either with a spouse, a relative, or in a nursing home. Sixty-nine percent of them lived in their own homes; 6 percent in apartments; 11 percent in Federal housing projects; and 14 percent in nursing homes.

The population of aging blind tends to correlate to the population of towns and cities. In the Project's catchment area, undoubtedly, the majority were located in cities over 10,000 in population. However, estimates were that the second greatest numbers of aging blind people lived in towns of under 1,000. When the populations of all the towns of this size were totaled, it was actually found that these had more people than did towns and/or cities with populations

of 1,000 to 5,000 or those of 5,000 to 10,000. Project statistics revealed that 39 percent of active clients were from cities of 10,000 and over, 26 percent were from towns of less than 1,000, 23 percent from towns of 1,000 to 5,000, and 12 percent from towns of 5,000 to 10,000. The Project ended before a thorough outreach of referrals was made in cities over 10,000 in population. The vast majority of referrals who were not seen were living in communities of more than 10,000.

One priority of services was given to those living in the most isolated situations. However, due to the isolation and the fact that many of these individuals were not known personally by townspeople, it was difficult to ascertain to what degree the Project was successful in this effort.

Another priority of Project services was directed to those living in their own homes. The numbers of aging blind clients served, therefore, do not truly reflect the percentages living in health care facilities where services were primarily given to those who expressed a desire to achieve more independence.

Services were provided to 22 persons living in nursing homes. There were eight additional persons living in their own homes who, during or after provision of services, were moved into health care facilities. Since these individuals had an onset of other severely disabling health conditions, no services could have prevented such institutionalization for most of these clients. However, one person, by his own choice, desired to live in a nursing home. He did not want to perform homemaking and housekeeping tasks for himself.

The social needs of the aging blind persons are somewhat reflected in their social affiliations. For the most part, social organizations were a meaningful part of the aging person's life. Seventy-four percent were found to have an active role in such organizations; 26 percent had little or no such affiliations. Church-related functions were by far the most common activities in which 47 percent participated. Twenty-four percent attended Federally funded or organized community social organizations, while 27 percent were involved in privately sponsored social organizations.

b. Service Needs

A needs assessment survey was completed on each individual client either in the first interview or as soon as he was willing to have the form completed. From this assessment an individualized written independent living plan was developed. In 23 percent of the cases, the initial assessed individual needs changed, resulting in staff writing addendums to the rehabilitation plans. This implies that other needs were identified later in the rehabilitation program in almost one fourth of the cases. To insure that clients' needs were

most fully met, each individual was given follow-up services at approximately one, three, six and twelve-month intervals throughout the Project. This also was to assure that each individual was given optimum opportunity to apply what he had been taught. A priority of services was always given to those who had previously received services yet had new needs arise.

One client who had been taught in the mobile unit was later found to have retained no measurable training benefit. Two who were taught in nursing homes also resulted in no such benefit. Eighteen other persons were identified as not having their expressed needs fully met. Reasons in order of frequency were:

(a) Refused services before plan was completed.

(b) Displayed an inhibiting lack of interest.

(c) Discontinued services due to exacerbated illness.

(d) Deceased prior to plan completion.

(e) Vision suitably restored.

(f) Could not comprehend.

(g) Unavailable to complete services.

The degree of improvement made by clients was difficult to measure. Staff marked on the survey the degree of improvement made by each individual in the categorical areas after services had been completed. The remainder of clients were rated as having made improvement to the extent that they were self-sufficient in specific categories. Also, even though some individuals had progressed to becoming independent in certain tasks, they still chose to remain dependent on other persons. The most common were males who were taught cooking and domestic tasks, yet their wives continued performing these activities of daily living. Although they did not make an everyday application of these skills, there were assurances they could utilize these skills if necessary. The pencil and paper method of comparing pre and post services benefits proved to be incomplete as an effective measure of the impact of services.

The grant provided for case services expenditures for clients. Individual case services funds were expended on 124 clients. The rationale for such expenditures was based on assisting individuals in their rehabilitation programs when no funds were available from personal, family, or any other community resources. Ophthalmological, general medical and audiological examinations, as well as canes were provided as diagnostic services. There were a few cases where

it was much more feasible and economical to pay for a current diagnostic examination rather than attempting to get this information from another agency. The average expenditure per client was $64.20. This final average was somewhat inflated due to one large expenditure for removing architectural barriers for one client.

By and large the case services funds did contribute to facilitating the rehabilitation programs of individuals. Hearing aids, in particular, were a prosthesis which in most instances would not have been provided through other existing private or public resources. Monies for medical reports also were not available through other sources. Generally medical reports would not be provided by medical specialists without cost. The medical reports proved to be valuable in planning individual rehabilitation programs because many of the clients had other severely limiting physical disabilities. There were instances where specialized medical examinations, professional low vision services and prosthetic devices such as glasses were not available in many smaller communities. Case services monies was very useful in providing aids and appliances. These included low vision aids, braille watches, braille clocks, and some of the more expensive writing aids.

A total of 258 resources were utilized in direct benefit to active clients, or an average of 1.6 per person. Thirty clients were provided other community services via referral and coordination by the Project staff. The majority of these resources were at no cost to the Project or to clients. Some of the most noteworthy were medical reports and consultation from general practitioners and medical specialists; also the services of the medical consultant retained by the State General Rehabilitation program.

The University of Northern Colorado Audiology Department furnished any indicated aural rehabilitation needs which included full audiological evaluation, hearing aid fitting and evaluation, and testing the effectiveness of existing hearing aids. University audiology staff and students provided a one-time field audiological evaluation to clients within some of the more rural counties. Three departments within the University also placed seven students for field experience with the Project. Two were vocational rehabilitation students, one of whom was from the visually handicapped area; and four orientation and mobility students in mini-practicums. The Gerontology and Psychology Departments of UNC arranged to provide course credit for students who volunteered to work with the Visual Awareness Programs.

This is certainly not a complete list, but these hopefully do reflect the impact of other community resources.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The original concept of the Project was to extend mobile services for aging blind into rural localities and to program with flexibility in meeting the needs of those individuals. The central focus was upon methods of providing services and the training of local resource people to work with blind persons. The physical modes used were a motor home, community facilities and clients' own homes. The training of local resource people included specific techniques which could be applied in locating referrals, motivating individuals to take part in services, and to teach clients how to be independent.

One of the first problems encountered was that of outreaching referrals. The aging blind have been called the "hidden blind". This was evidenced by the fact that only four percent of all referrals were self initiated and that intensive efforts were required in locating this population. The volunteer endeavors of visual screening programs and public education were, however, effective means not only of locating clients, but also proved to be one of the Project's successful efforts in providing instruction on prevention of blindness to the aging population, professionals, para-professionals and the public in general.

There was a high incidence of prospective clients who refused services. Future efforts should be made to clarify why such persons may not be receptive. This investigation should include:

1. Reasons why people are not interested in services.

2. A more thorough evaluation of individuals' satisfaction and adjustment, especially in cases where the family and/or others perform many of their daily tasks or even respond for them.

3. A more complete study on the personal and family interrelationships which likely could be depriving individuals of services. (See study conducted by Mr. Stephen Hey, "The Social Life of the Elderly Blind Within an Independent Senior Citizen Housing Complex".)

4. An indepth review of the effect of agency or governmental labels of programs. The Project found that it was best to de-emphasize their State Department designation of Social Services which was almost universally associated with the stigma of Welfare.

5. The application of volunteer or paid peer rehabilitation teachers deserves considerably more demonstration. Not only could such a program effectively assist in bringing about receptivity for services, but also definitely could provide a more intensive, expanded and improved services complement to a professional staff.

The majority of persons who were ineligible for services was because they were not legally blind. Legal blindness is questionable and incomplete as a determination of who should or should not receive services. Since the goal of this program was to assist the visually impaired individual become as fully independent as possible, the person's ability to perform activities of daily living as a direct result of visual loss should have been the focus of assessment and services. This should be the primary consideration for determination of eligibility.

In providing services to the aging blind by the use of a mobile training unit, the disadvantages outweighed the advantages. In the original application, the concept of a mobile training unit was proposed as one of the measures of the Project's success. Experience, however, has shown this method was only one of three alternative modes of service delivery possible in the Project area. It was assumed that this mode would offer a meaningful transition out of the home for the homebound person, and that it would provide opportunities for social activities.

Clients, however, did not prefer this modality. The unit did not in and of itself show potential for expanding a client's life style. Even though in many areas facilities for senior citizens and related organizations were not suitably equipped for teaching, they could well be used for socialization. It was felt by Project staff that home teaching, orientation and mobility and counseling services are best provided in and about one's home.

The unit's architectural barriers contradicted the Project's purpose of "teaching independence". Although the barriers were potentially removable, the cost could not be justified in light of the numerous other factors. The best use of the unit for the aging blind and other disabled population seems to be short term individualized services such as specialized evaluations and examinations, particularly for those in nursing homes.

If an agency, however, desires to provide services by the use of a mobile unit, it is recommended that:

1. Care be taken to clearly design the services to be offered. This should be based on actual experience and knowledge of needs of the targeted population. A thorough knowledge of existing community resources and facilities throughout the catchment area is necessary.

2. Planning include possibilities of a multi-agency approach. It is questionable whether any one agency can fully apply such a concept alone.

3. Consideration be given to the potential operator and the qualifications necessary for operation of the vehicle. Maintenance and repair resources should be planned before purchasing the unit.

4. The vehicle be custom designed with adequate space for the older blind person to navigate. All noise-emitting should be insulated.

5. Review literature concerning use of mobile units in delivering services to the aging and disabled. A recommended reference is Planning Handbook, Transportation Services for the Elderly, which is designed to assist in planning and running a special transportation service.[2]

Relocating clients to provide services within community facilities was not found to be desirable in providing rehabilitation teaching and counseling services. The use of these facilities was not as effective in teaching as was teaching in well known surroundings. The community facilities were, however, quite worthwhile for in-service training, socialization and related activities.

It was found, on the other hand, that providing teaching services in clients' homes was very effective. This was due, in part, because evaluation and training could be done in situations with household equipment and furnishings which were an integral part of normal daily living. Orientation and mobility was also found to be more appropriate when taught in the clients' own locality. The most compatible teaching of mobility was based on clients' desires in travel which usually resulted in route training. Generally this population preferred to receive services and to remain in familiar environments. This is a significant argument against providing services to the majority of this population in a rehabilitation center model.

The aging process does create a change in the functional abilities of many individuals. This results in a need for special techniques to work with these people. It was common to work with clients with decreased ability in performing tasks of tactual perception. Staff focused often on teaching tactual discrimination. Improvement was successful in some cases, while adaptive aids also proved beneficial. There was also a problem of retention of learning. Since learning did usually take longer, it was important to develop an individualized pace for each person. Repeated rehersal of skills was generally effective. The long range retention of skills learned cannot be specified at this time. The Project's duration did not allow for sufficient post services time to measure long term results.

[2]Institute of Public Administration, Planning Handbook, Transportation for the Elderly, Washington, D.C.: Administration on the Aging, November, 1975, p. I-1.

However, it cannot be assumed that skills learned, such as orientation and mobility or rehabilitation teaching, will significantly reduce institutionalization, especially in health care facilities. The greatest factor of admittance to such facilities was disease and the residual consequences of physical limitations. The Project had no demonstrative evidence of diminishing admittance to nursing homes or being effective in assisting those aging blind in nursing homes to live in more independent situations. Primary services which could directly affect independent living adaptation would be specialized medical care and financial support. Many financial resources for support are presently available through public resources, perhaps the most comprehensive being Medicaid and other Department of Social Services programs.

The Project did make inroads into methods and techniques. It also brought to light factors which bear further investigation or comment:

1. The majority of aging blind persons were found to have other disabilities. Skills of professionals to effectively work with this population supercedes skills currently being taught to graduates and undergraduates in the visually handicapped field. Areas which require notably more attention in education are:

    a. Specific rehabilitative skills in working with other disabilities and effects of disease commonly associated with aging. This includes a knowledge of the aging process, its medical and psychological aspects, and techniques effective with this population.

    b. The high incidence of hearing impairments and deaf-blindness in those over 65 years of age indicates need for an introductory background in aural rehabilitation, effective methods of communicating, knowledge of the aging manifestation of presbycusis, and available resources.

    c. Theory and techniques in interviewing and counseling the aging person are necessary. There should be considerable direction into motivational theory, family counseling, group dynamics and related techniques. It is concluded that the aging blind person is unique to motivate, does require special approaches, and that the family unit is an important part of his rehabilitation program.

    d. A preliminary knowledge of nutrition and special diets of the aging adult would be beneficial to rehabilitation teachers.

    e. A knowledge in recreational and exercise activities for the aging is important, especially hobbies and crafts. Basic home repair instruction could be very worthwhile for males. (See "Working With the Disabled Homemaker" by Jane Quiroz.)

2. Research should be done on the effects of social isolation of the aged. Many clients of the Project refused to attend social functions because they preferred isolated situations. While they did prefer isolation, there was no solid evidence which showed isolation to be an unhealthy adjustment. The effects of social isolation, therefore, must be interpreted very carefully. Apparently the quality of socialization and stable relationships is more important than the quantity of socialization. Perhaps one of the greatest drawbacks of organized socialization groups for the aging was the tendency to develop innumerable activities, with anticipated large attendance, which did not directly contribute to building close relationships. In fact, many activities were geared toward a more competitive environment which tended to exclude those who were withdrawn. It should be noted that an essential part of the teaching process was to allow time for socialization on a one-to-one basis.

3. Other grants-in-aid requests should include funding to design quality evaluation and tools to effectively measure the aging blind person's degree of improvement, the full impact of in-service training and other specific measures of quality. Monies should also be requested for computerization of impact or outcome measures.

4. Studies need to be directed more toward minority groups such as the migrant worker.

5. The value of trained volunteers or paid peers in directly providing services needs to be fully explored. It is believed they could have good results in expanding services to this population at a very nominal cost.

6. Federal assistance should be considered in providing comprehensive rehabilitation services to this population. This should include client case services monies for completion of independent living plans.

7. New projects should consider expansion of coordinated community agency and organization activities. There are private agencies, for example, who sponsor individualized community projects for the disabled and blind, but most were found to give little consideration to the aging blind. Experience of this project has led to the conclusion that community resources are indeed an essential ingredient to a multi-dimensional and disciplinary approach in working with this population. Without doubt this is among the most demonstrated effective method of providing quality service.

8. Direction should be given to more clearly identify the aging deaf-blind population and subsequently develop programs designed to meet their rehabilitation needs.

REFERENCES

Bell, Bull D., editor. Contemporary Social Gerontology, Significant Developments in the Field of Aging. Charles C. Thomas, Springfield, Illinois, 1976.

First National Converence on Aging & Blindness. Theme: Meeting the Challenges of Elderly Persons with Sight Difficulties, Action '76. New Orleans, April 24-26, 1975.

Goldberg, Maxwell H., Swinton, John R. Blindness Research: The Expanding Frontiers, A Liberal Studies Perspective. The Pennsylvania State University Press, Pittsburg, 1969.

Interstate Research Associates. A Community Centered Program for the Chicano Aged. AOA Grant #93-P-55904/3-01, Colorado: Interstate Research Associates.

Kimmel, Douglas C. Adulthood and Aging, An Interdisciplinary View. John Wiley & Sons, Inc., New York, 1974.

Lenzer, Anthony. Health Care Services. Lecture, May, 1973.

Saul, Shura. Aging: An Album of People Growing Old. John Wiley & Sons, Inc., New York, 1974.

Utah State Board of Education. Preliminary Geriatric Visual Screening Survey. Utah: Adult Education & Training, 1974.

APPENDIX A

TABLES

TABLE 1

STATUSES OF REFERRALS

EFERRAL SOURCE	TOTAL REFERRALS	ACTIVE	REFUSED SERVICES	INELIGIBLE	REFERRALS* UNSEEN
ept. of Social Services	109	38	27	26	18
isual Awareness Program	106	12	16	0	78
egister of the Blind	95	18	19	2	56
riends & Relatives	53	22	20	6	5
ublic Health Nurses	45	11	14	15	5
ouncils on Aging	34	10	14	9	1
phthalmologists	25	16	7	1	1
elf Referral	24	12	4	7	1
lients	22	5	9	4	4
ursing Homes	18	7	6	1	4
olunteers	17	0	7	8	2
esources & Referral Systems	12	3	3	2	4
enior Citizens	11	4	1	6	0
ousing Authorities	9	1	6	2	0
etired Senior Volunteers Program	8	2	6	0	0
ptometrists	5	2	1	2	0
thers	27	3	9	7	8
OTAL	620	166	169	98	187

Referrals on rolls at termination of Project.

VISUAL SCREENING RESULTS

INDEPENDENT LIVING GERIATRICS

CREENING	NUMBER SCREENED	AVERAGE AGE MALE-FEMALE	NUMBER SATISFIED WITH VISION	NUMBER PASSED SCREENING	NUMBER FAILED SCREENING	NUMBER FAILED NEAR BOTH EYES	LEGALLY BLIND	PARTIALLY SIGHTED
#1	16	11 F- 76.8 5 M- 79.4 Both- 77.6	6	7	9	3	4	0
#2	11	8 F- 74.2 3 M- 52.0 Both- 68.0	5	5	6	2	2	0
#3	21	16 F- 71.8 5 M- 76.2 Both- 72.8	14	9	12	7	0	1
#4	26	18 F- 65.9 8 M- 73.0 Both- 68.1	14	13	13	8	1	1
#5	20	15 F- 68.5 5 M- 67.2 Both- 68.2	15	15	5	0	0	0
#6	16	13 F- 66.23 3 M- 66.0 Both- 66.18	12	9	7	5	0	1
#7	5	3 F- 70.3 2 M- 77.5 Both- 73.2	4	5	0	0	0	0
#8	7	6 F- 71.8 1 M- 76.0 Both- 72.4	2	2	5	2	1	0
#9	15	12 F- 76.7 3 M- 68.7 Both- 75.0	6	2	13	5	0	0
#10	5	4 F- 71.0 1 M- 77.0 Both- 72.0	1	2	3	2	0	1
TOTAL	142	106 F- 70.87 36 M- 71.27 Both- 70.97	79 (55%)	69 (48%)	73 (51%)	34 (23%)	8 (5%)	4 (2%)

TABLE 3

VISUAL SCREENING RESULTS

HEALTH CARE FACILITIES

CREENING	NUMBER SCREENED	AVERAGE AGE MALE-FEMALE	NUMBER SATISFIED WITH VISION	NUMBER PASSED SCREENING	NUMBER FAILED SCREENING	NUMBER FAILED NEAR BOTH EYES	LEGALLY BLIND	PARTIALLY SIGHTED
#1	39	28 F- 79.6 11 M- 81.8 Both- 80.3	19	6	32	15	5	3
#2	56	44 F- 81.8 12 M- 79.4 Both- 81.3	30	20	36	10	8	3
#3	58	45 F- 84.8 13 M- 86.3 Both- 85.2	27	5	43	23	9	9
#4	29	16 F- 58.8 13 M- 56.8 Both- 57.9	12	7	8	3	2	1
#5	104	80 F- 77.5 24 M- 79.3 Both- 77.9	50	31	62	29	13	14
#6	60	44 F- 76.4 16 M- 68.8 Both- 74.5	26	16	39	22	6	13
#7	23	13 F- 77.6 10 M- 81.3 Both- 79.3	9	5	15	9	1	7
TOTAL	369	270 F- 79.6 99 M- 79.0 Both- 79.4	173 (45%)	90 (28%)	235 (72%)	111 (34%)	44 (14%)	50 (15%)

TABLE 4

SOURCE OF SUPPORT

	NUMBER	PERCENTAGE
Social Security	38	23%
Social Security and Savings	24	14%
Social Security and Private Pension	22	13%
SSI and DSS	16	10%
Social Security and Social Services	14	8%
OAP	13	8%
Other	11	7%
Unknown (undisclosed)	9	5%
Social Security and Farm or Ranch Income	8	5%
SSDI, SSI, and DSS	8	5%
Private Pension	3	2%

TABLE 5

OTHER PHYSICAL DISORDERS

	INCIDENCE OF FREQUENCY
Cardiovascular (Including Arterioschlerosis, Strokes, and Hypertension)	54
Hearing Impairments	44
Arthritis	37
Metabolic Disorders	23
Respiratory (Emphysema and Bronchitis)	8
Gastrointestinal	8
Obesity	7
Urinary	5
Neurological	4
Cancer	3
Skeletal Deformities	2
Severe Skin Disorders	2

TABLE 6

SERVICES PROVIDED

	INCIDENCE OF FREQUENCY	PERCENTAGE
COMMUNICATION SKILLS:		
Use of handwriting guides	92	55%
Use of telephone	52	31%
Low vision services	49	30%
Telling time	24	14%
Telephone number organization	20	12%
Typing	14	8%
Use of large print	11	7%
Braille	11	7%
Social graces	1	.6%
HOME MANAGEMENT & ORGANIZATION:		
Eating skills and plate organization Food Preparation	32	19%
Measuring techniques	30	18%
Kitchen safety techniques	22	13%
Labeling kitchen goods	20	12%
Cooking techniques	18	11%
Use of kitchen aids and appliances	12	7%
Cutting techniques	10	6%
Menu planning and organization	8	5%
Sandwich preparation	2	1%
Taping recipes	2	1%
HOUSEKEEPING:		
Mending and sewing	37	22%
General home management housekeeping	14	8%
Ironing	1	.6%
Laundering	1	.6%
PERSONAL MANAGEMENT:		
Coin/currency identification	65	39%
Personal care and grooming	13	8%
Clothing identification	5	3%
Budgeting of finances	2	1%
Use of abacus	3	2%
Development of tactual discrimination	2	1%
LEISURE TIME ACTIVITIES:		
Use of talking book machine	56	34%
Other activities	25	15%
Hobbies and crafts	9	5%

TABLE 6

SERVICES PROVIDED

	INCIDENCE OF FREQUENCY	PERCENTAGE
MOBILITY:		
Cane travel (orthopedic cane)	28	17%
Cane as an identification aid	14	8%
Precane skills	2	1%
Alignment	2	1%
Block travel	1	.6%
Ascending/descending stairs	8	5%
Business travel	3	2%
Diagonal technique	11	7%
Depth perception	13	8%
Familiarization	2	1%
Indoor travel	3	2%
Locate key areas	2	1%
Orientation	11	7%
Rural travel	1	.6%
Route planning	1	.6%
Sighted guide	34	20%
Seating	1	.6%
Protective technique	12	7%
Residential travel routes	1	.6%
Street crossing	8	5%
Search techniques	7	4%
Trailing	5	3%
Touch technique	8	5%
Tactual maps	1	.6%
OTHER TRAINING:		
Intensive personal counseling	23	14%
Removal of architectural barriers	2	1%
Employment (sheltered)	2	1%
Housing relocation	4	2%
Socialization involvement	13	7%

TABLE 7

CASE SERVICE EXPENDITURES

	INCIDENCE OF FREQUENCY	PERCENTAGE
CATEGORICAL EXPENDITURE:		
Medical & Related		
General medical examinations	36	22%
Ophthalmological examinations	35	21%
Audiological examinations*	17	10%
General medical reports	8	5%
Ophthalmological reports	6	4%
Otological examinations	6	4%
Hearing aids	5	3%
Professional low vision evaluations	4	2%
Neurological examinations	3	2%
Glasses	3	2%
Cataract surgery (portion only)	1	.6%
Prosthetic evaluation	1	.6%
Braille insulgage	1	.6%
TRANSPORTATION:		
Diagnostic and training	9	5%
TEACHING SUPPLIES:		
Canes	56	34%
Writing aids and reading aids	28	17%
Low visions aids	26	16%
Kitchen aids and appliances	20	12%
Time telling aids	11	6%
Leisure time aids	5	3%
Kitchen improvements	1	.6%

*Twelve clients requiring audiological examinations received such at no cost through the University of Northern Colorado, Audiological Department.

APPENDIX B

VISUAL AWARENESS PROGRAM MATERIALS

EDUCATIONAL PROGRAM ON EYE CARE

FOR OLDER PERSONS

SERVICES FOR THE OLDER VISUALLY IMPAIRED

THIS IS AN "EDUCATIONAL" PROGRAM PRIMARILY FOR THE OLDER CITIZENS OF WELD COUNTY OPERATED ENTIRELY BY VOLUNTEERS. THE PURPOSE IS TO ASSIST IN BRINGING ABOUT IMPROVED EYE CARE, UTILIZATION OF REHABILITATIVE RESOURCES FOR THE VISUALLY IMPAIRED, AND GENERAL AWARENESS OF EYE SAFETY AND CARE AND KNOWLEDGE OF VISUAL IMPAIRMENT BY THE OLDER POPULATION. VISUAL SCREENING PROGRAMS ARE CONDUCTED THROUGHOUT THE COUNTY IN COOPERATION WITH OTHER PROFESSIONAL ORGANIZATIONS, AND AGENCIES. SERVICES ARE PROVIDED TO OLDER RESIDENTS LIVING INDEPENDENTLY, AS WELL AS THOSE IN NURSING HOMES AND RELATED CARE FACILITIES. PROGRAMS ARE ALSO CONDUCTED TO BRING ABOUT A MORE FULL UNDERSTANDING OF EYE CARE AND VISUAL IMPAIRMENT VIA VIDEO TAPES, BROCHURES, PAMPHLETS, AND DISCUSSION.

AN EXAMPLE OF HOW THE PROGRAM WORKS MIGHT BE AS FOLLOWS: A NURSING HOME FEELS THERE IS A NEED FOR BETTER EYE CARE OF RESIDENTS AND STAFF MIGHT BENEFIT FROM MORE KNOWLEDGE OF CATARACTS. A FILM COULD BE PRESENTED, LITERATURE DISPERSED, AND DISCUSSION COULD BE PRESENTED ON THAT SUBJECT. A VISUAL SCREENING PROGRAM WOULD BE ORGANIZED FOR RESIDENTS, BOTH FOR THOSE WHO ARE MOBILE AND THOSE WHO ARE BEDRIDDEN TO IDENTIFY THOSE IN NEED OF EYE CARE AND/OR OTHER REHABILITATIVE SERVICES. A MAJOR THRUST AND VALUE OF THE PROGRAM IS TO ASSIST THOSE IN NEED OR OPHTHALMOLOGICAL OR OPTOMETRIC SERVICES, REHABILITATIVE SERVICES, AND FINANCIAL ASSISTANCE TO RECEIVE SUCH SERVICES. AN EXAMPLE MIGHT BE THAT MRS. JONES IN A NURSING HOME IS IN NEED OF A CURRENT PROFESSIONAL EXAMINATION AND PERHAPS GLASSES, YET SHE NOR HER FAMILY CAN AFFORD THE SERVICE. A VOLUNTEER COULD ASSIST IN WORKING OUT THE DETAILS FOR FINANCIAL SUPPORT FROM AN EXISTING COMMUNITY RESOURCE AND THE ACTUAL APPOINTMENT TO RECEIVE SUCH SERVICES FROM THE EYE SPECIALIST OF MRS. JONES' CHOICE.

IF YOU ARE AWARE OF ANY GROUP OF ESPECIALLY OLDER PERSONS WHO ARE IN NEED OF SUCH SERVICES OR IF YOU ARE INTERESTED IN BECOMING A VOLUNTEER TO BE TRAINED, PLEASE CONTACT MRS. C. B. WOOD, PROGRAM COORDINATOR, AT 1712 MONTVIEW BOULEVARD, TELEPHONE 352-6819 OR MR. RON LANDWEHR, 2662-C 11th AVENUE, TELEPHONE 356-9393.

RAL/cl

9/76

VISUAL AWARENESS PROGRAM

A Volunteer Endeavor

THIS IS AN "EDUCATIONAL" PROGRAM PRIMARILY FOR THE OLDER CITIZENS OF LARIMER COUNTY OPERATED ENTIRELY BY VOLUNTEERS. THE PURPOSE IS TO ASSIST IN BRINGING ABOUT IMPROVED EYE CARE, UTILIZATION OF REHABILITATIVE RESOURCES FOR THE VISUALLY IMPAIRED, AND GENERAL AWARENESS OF EYE SAFETY AND CARE AND KNOWLEDGE OF VISUAL IMPAIRMENT BY THE OLDER POPULATION. VISUAL SCREENING PROGRAMS ARE CONDUCTED THROUGHOUT THE COUNTY IN COOPERATION WITH OTHER PROFESSIONAL ORGANIZATIONS, AND AGENCIES. SERVICES ARE PROVIDED TO OLDER RESIDENTS LIVING INDEPENDENTLY, AS WELL AS THOSE IN NURSING HOMES AND RELATED CARE FACILITIES. PROGRAMS ARE ALSO CONDUCTED TO BRING ABOUT A MORE FULL UNDERSTANDING OF EYE CARE AND VISUAL IMPAIRMENT VIA VIDEO TAPES, BROCHURES, PAMPHLETS, AND DISCUSSION.

AN EXAMPLE OF HOW THE PROGRAM WORKS MIGHT BE AS FOLLOWS: A NURSING HOME FEELS THERE IS A NEED FOR BETTER EYE CARE OF RESIDENTS AND STAFF MIGHT BENEFIT FROM MORE KNOWLEDGE OF CATARACTS. A FILM COULD BE PRESENTED, LITERATURE DISPERSED, AND DISCUSSION COULD BE PRESENTED ON THAT SUBJECT. A VISUAL SCREENING PROGRAM WOULD BE ORGANIZED FOR RESIDENTS, BOTH FOR THOSE WHO ARE MOBILE AND THOSE WHO ARE BEDRIDDEN TO IDENTIFY THOSE IN POSSIBLE NEED OF EYE CARE AND/OR OTHER REHABILITATIVE SERVICES. A MAJOR THRUST AND VALUE OF THE PROGRAM IS TO ASSIST THOSE IN NEED OF OPHTHALMOLOGICAL OR OPTOMETRIC SERVICES, REHABILITATIVE SERVICES, AND FINANCIAL ASSISTANCE, TO RECEIVE SUCH SERVICES. AN EXAMPLE MIGHT BE THAT MRS. JONES IN A NURSING HOME IS IN NEED OF A CURRENT PROFESSIONAL EXAMINATION AND PERHAPS GLASSES, YET SHE NOR HER FAMILY CAN AFFORD THE SERVICE. A VOLUNTEER COULD ASSIST IN WORKING OUT THE DETAILS FOR FINANCIAL SUPPORT FROM AN EXISTING COMMUNITY RESOURCE AND THE ACTUAL APPOINTMENT TO RECEIVE SUCH SERVICES FROM THE EYE SPECIALIST OF MRS. JONES' CHOICE.

IF YOU ARE AWARE OF ANY GROUP OF ESPECIALLY OLDER PERSONS WHO ARE IN NEED OF SUCH SERVICES OR IF YOU ARE INTERESTED IN BECOMING A VOLUNTEER TO BE TRAINED, PLEASE CONTACT MRS. CHARLOTTE KANODE, AT 519 EDWARDS, TELEPHONE 484-0178, OR MRS. ADELE SCHELL, AT 1978 DORSET DRIVE, TELEPHONE 493-1932.

RAL/cl
2/7/77

VISUAL AWARENESS PROGRAM

A Volunteer Educational Endeavor

Dear

On _____ 19____, you particiapted in a visual screening program in/at _____.

Results _____

_____

_____

Suggestions _____

_____

_____

Hopefully, this information will be helpful to you. If you have questions or need of assistance, please feel free to contact me.

_____

Name

_____

Address

_____

Phone

VISUAL AWARENESS PROGRAM

A volunteer Educational Endeavor

Dear

On _____ 19____, you participated in a visual screening program in/at _____.

Results _____

_____

_____

Suggestions _____

_____

_____

Hopefully, this information will be helpful to you. If you have questions or need of assistance, please feel free to contact me.

_____

Name

_____

Address

_____

Phone

VISION SCREENING RECORD

Name_____ Date of Birth_____

Address_____ Age_____

City_____ Phone Number_____

State/Zip Code

* *

Questionnaire:

1. Are you satisfied with your present vision?____ If not, what would you like to see better?_____

2. Do you have any eye diseases, or have you had an eye injury? If yes, please comment:_____

3. Have you had any eye surgery?____ If yes, please comment:_____

4. Do you wear glasses or use magnifiers? Glasses:_____ Magnifiers:_____

5. Do you have any of the following symptoms or conditions (Yes or No):

_____	Rings or halos around lights.	Comments:_____
_____	Flashing lights before the eye(s).	
_____	Frequent pain in the eye(s).	
_____	Pain in your eyes at night.	
_____	Black spot in center of vision.	
_____	New black specks before your eye(s).	
_____	Colors becoming less clear.	
_____	Blurring of vision.	
_____	Change in field (side) vision.	
_____	Diabetes.	
_____	Changes in vision, in the last 6 mos.	
_____	Presently on prescribed medications.	

Screenees Comments:_____

* *

SCREENING RESULTS

Far Vision	With Glasses	Without Glasses
Right eye	_____	_____
Left eye	_____	_____
Both eyes	_____	_____

Near Vision	With Glasses	Without Glasses
Right eye	_____	_____
Left eye	_____	_____
Both eyes	_____	_____

Pinhole Vision	With Glasses	Without Glasses
Right eye	_____	_____
Left eye	_____	_____

Condition of glasses, comment:_____

Visual Screening: Pass_____ Fail_____

Not examined because: Unable to creeen:____ Refused:____ Unavailable:____

Under treatment:____

Date of screening:_____ Screening location:_____

Date of last eye examination:_____ Under care of eye specialist?_____

Name and address of eye care practioner:_____

* *

Screener's Comments:_____

Signature of Examiner:_____

* *

Final Disposition:_____

RAL/cl 6/30/76

PROCEDURE FOR SCREENING THE ELDERLY

Before the screening commences, clean the individual's glasses. If he is not wearing glasses, ask if he normally wears glasses. The screening should be done with the glasses on. If the client is not wearing glasses, note it on the form.

Place the self-illuminating distant Snellen Chart at a measured 20 feet from the person to be tested. If standard Snellen Distant Charts are to be utilized, a high intensity lamp should be placed to illuminate uniformly on the chart. An extension cord may be required to enable the chart to be plugged in.

The illumination of the room should be uniform. Draw the drapes to prevent glare that might interfere with the test. Overhead lights should be left on.

The individual should be seated in a chair 20 feet from the chart. If space does not allow, a 10 foot Snellen Chart may be used at the correct measured distance, but is recommended only when there is insufficient space for the 20 foot chart. A chair should be used by the examiner and a small table should also be used for recording the results. The table may be used to keep the instruments and the high intensity lamp on. Place the table next to the person to be screened and situate the lamp where it can illuminate the near Reduced Snellen Chart from the rear when held by the client.

DISTANT VISUAL ACUITY SCREENING

The individual is given an occluder and instructed to place it over the left eye. If he is too shakey, the examiner should hold it for him. The individual is asked to read the lowest line he can on the chart. Record the results. If the client reads half or more of the letters on a given line, it should be recorded as that line being read. If less than half the letters are read, record the above line. The client is next instructed to occlude the right eye and read the chart with the left eye. The chart is then read with both eyes.

Repeat the screening, if the client fails, or if there is a question of validity of the first screening.

After second trial with glasses, record only the second screening. Next, screen the right, then the left, then both eyes without glasses. If vision is better, likely the person 1) Does not have a glass prescription for distant vision, or 2) Needs a new professional eye examination if he or she fails the screening. If the individual

fails the screening both with and without glasses, check first the right then the left eye with the pinhole occluder. If vision improves, likely, the person will benefit from a more current refraction. The pinhole testing, however, should never be used to lead people to believe that you can predict or are in a position to diagnose or prognose eye care needs.

REFERRAL CRITERION FOR DISTANT VISUAL ACUITY

If client is 65 years old or under, a referral should be made if the visual acuity is less than 20/40 in either eye.

Example: Right eye: 20/20
Left eye: 20/50 -- The client should be referred.
Both eyes: 20/20

Example: Right eye: 20/20
Left eye: 20/40 -- The client should not be referred.
Both eyes: 20/20

If the client is over 65 years of age, he should be referred if the visual acuity is less than 20/60 in either eye.

Example: Right eye: 20/30
Left eye: 20/70 -- The should be referred.
Both eyes: 20/30

Example: Right eye: 20/50
Left eye: 20/60 -- The client should not be referred.
Both eyes: 20/40

If there is a difference of 3 lines or more in the acuities, refer the client if over 65 years of age.

Example: Right eye: 20/50 -- Refer the client
Left eye: 20/20
Both eyes: 20/20

NEAR VISUAL ACUITY SCREENING

The high intensity lamp is turned on to illuminate the reduced Snellen Chart.

The chart should be held at 16 inches, or the most comfortable reading distance for the client. The client is instructed to occlude the left eye and read the lowest line he can. If he is shakey, the examiner should hold the card or use a place holder. Record the results, and then test the left eye and then both eyes together.

Repeat the test, if the client fails.

If the person stated he or she uses a magnifier and fails the screening, he or she should be screened while using the magnifying aid. However, pass or fail, is based on use of best corrected vision, whether it be "with" or "without glasses".

REFERRAL CRITERION FOR NEAR VISUAL ACUITY

If the individual's visual acuity is less than 20/40 in either eye, the person should be referred:

Note: There is no age discrimination in referring at near.

Example: Right eye: 20/20
Left eye: 20/60 -- Refer the client.
Both eyes: 20/20

Example: Right eye: 20/40
Left eye: 20/40 -- Do not refer the client.
Both eyes: 20/40

Items Used for Screening:

1. Self-Illuminating Distant Snellen Chart(s).
2. Reduced Snellen Chart(s).
3. Occluder.
4. High Intensity Lamp(s).
5. Tape Measure.
6. Extension Cord(s).
7. Material to clean glasses.
8. Masking tape.

Definition of Vision Screening Record

Form is to be filled out legibly. PLEASE, completely fill out form starting with name, address, city, state, zip code, date of birth, age and telephone number.

QUESTIONNAIRE

1. Is person satisfied with present vision, yes or no. If not, be specific about what he or she would like to see better, e.g. Reading. Reading What? Print varies in size. It is best to know what they would like to read as to give ophthalmologists and optometrists a clearer idea of what the person desires in corrected vision, if referred.

2. Do not belabor if the person feels they have an eye disease. This could result in endless conversation. If they state symptoms, comment on such. If most people have an eye disease, they can only tell you what it effects, not the medical term. If the person has had an eye injury, ask approximately when and what it was and write a brief comment.

3. If the individual has had eye surgery, comment as to when and give some idea, if available, as to indicate for what purpose.

4. If the person wears glasses or uses a magnifier, mark yes, if not, no. Always ask, never assume that just because they may not be wearing glasses that they do not use such. If the individual uses a magnifier, hopefully, he has been advised to bring such and later, during the screening, is requested to use it, especially if he cannot pass the near visual acuity examination.

5. Merely ask the individual if he has any of the listed symptoms or conditions. The answers are either yes or no. If the person specifies certain symptoms or conditions, the right column comment section may be used for such comments.

Screenees Comments: Any judged relative comments made by the person being screened may be entered here.

SCREENING RESULTS

1. Far Vision: "See procedure for Far Visual Acuity Screening". The most important measure of vision is with glasses, IF THE PRESCRIPTION WAS FOR DISTANT VISION. If their coorective lens prescription happens to be only for near point correction, or if the individual fails or has difficulty with the distant visual screening, an option is to test without glasses. Results are to be entered under column "without glasses". If person fails both "with glasses" and "without glasses", the third option is to test with pinhole occluder. Right and left eye results are to be recorded when performed. If refraction will be beneficial, the pinhole evaluation should give indication.

2. Near Vision: Test right eye, then left, and both and record results while wearing glasses. If individual has an eyeglass prescription for distant vision only or has difficulty or fails, the person should be screened without glasses and results should be entered in "without glasses" column. If person has stated they use a magnifier and they fail nearpoint, they should be encouraged to use their magnifier in a final screening. Results should be entered in screener comment section with appropriate notations.

3. Condition of glasses: Make brief notation as to condition of glasses. If good, enter such, or some similar notation. If poor, specify, e.g. frames bent, nose piece bent, scratched lenses, etc.

4. Not examined because: If person is incapable of being screened, check the appropriate reason.

5. Date of screening: Month, day and year in which screening is being conducted.

6. Screening Location: Enter place and city or town where screening is being conducted.

7. Date of last eye examination: The most accurate date that can be solicited from the examinee as to when he had his last examination from an "eye specialist", whether ophthalmologist or optometrist.

8. Under care of an eye specialist?: Write either yes or no as to whether the individual is presently under the care of an ophthalmologist or optometrist.

9. Name and address of eye care practitioner: Enter the name and at least city or town of last ophthalmologist or optometrist seen. If specialist practices outside Weld County, it would be well to get the most complete address possible if the client can remember.

10. Screeners Comments: This is reserved for brief comments of the person who has performed the screening. Comments are of any significant or relevant data. A few examples are: Results of screening with a magnifier, specific recommendations for referring, any unusual aspects, further elaboration on any parts of the vision screening record, etc.

11. Signature of examiner: The person who performs the vision screening signs his or her name here.

12. Final Disposition: Do Not Use This Space. This is to be used only by the persons who actually follow up required services for individuals. The results of referring persons for ophthalmological, optometric, optical, rehabilitative, financial assistance will be entered here at a later date. The results will be evaluated.

FINANCIAL AND REHABILITATIVE SERVICES
FOR
THE VISUALLY IMPAIRED

This is not an inclusive list of all financial/rehabilitative resources in Weld County, but constitutes the majority. The eligibility for each organization and services provided are included. The determination of eligibility cannot be made by you, but must be made by the organization (when applicable).

COLORADO STATE DIVISION OF REHABILITATION

Contact: Roger Cozens, Supervisor
Address: 938 13th Street, Greeley, CO 80631
Telephone: 352-5180

Eligibility Requirements: 1) An individual must have a physical or mental disability which results in a substantial handicap for employment. 2) There must be a reasonable expectation that through the provision of services that the individual be able to enter gainful employment. There are no age requirements, the person must be legally permitted to work in the United States, and does not require an established residency.

Services: The agency may provide any diagnostic, evaluative, restorative, training, educational, etc., service which will assist the individual in eventually entering employment. Employment includes competitive remunerative work, homemaking, and sheltered employment.

COLORADO STATE SERVICES FOR THE OLDER VISUALLY IMPAIRED

Contact: Ron Landwehr, Supervisor
Address: 2662-C 11th Avenue, Greeley, CO 80631
Telephone: 356-9393

Eligibility Requirements: 1) The individual must be 55 years of age or over, 2) Must be "legally blind" or medical evidence can be secured which evidences to person to be becoming blind "in a reasonable period of time", 3) By a combination of age and disability, not likely to be eligible for existing rehabilitation services. Has no potential or aspirations for competitive employment.

Services: Any diagnostic, evaluative, restorative, or related services, home teaching, counseling and orientation and mobility services to assist the individual and family in becoming as independent as possible.

COLORADO STATE SERVICES FOR THE VISUALLY IMPAIRED

Contact: Bob Caron, Rehabilitation Counselor
Address: 938 13th Street, Greeley, CO 80631
Telephone: 352-5180

Colorado State Services for the Visually Impaired (Continued)

Eligibility Requirements: Agency works with disabled persons who are both vocationally and non-vocationally eligible. Vocational Rehabilitation eligibility: 1) Must have a visual impairment that results in a substantial handicap to employment. 2) There must be a reasonable expectation that services rendered can assist the individual to enter gainful employment.
Non-vocational Rehabilitation eligibility: 1) Must be at least "legally blind".

Services: For the vocationally eligible, provides any diagnostic, evaluative, restorative, training, educational, vocational placement, and related services which will assist the individual in entering gainful employment, whether competitive, homemaking, or sheltered. For those who are not eligible or do not aspire to gainful employment, may provide counseling and home teaching services.

EAST SIDE HEALTH CENTER (Programa De Salud De Northern Colorado)

Contact: Mrs. Pat Faye, Director or Steve Sutton, Supervisor of Outreach Services
Address: Gill, Colorado 80624
Telephone: 356-6014

Eligibility Requirements: Will provide health or medical related services to any person. Need not have state residency. Geographic catchment area is the northern half of Weld County and Larimer and Morgan Counties. Client pays for services based on amount of income, not to be less than 10% of medical costs. Program more toward serving the migrant worker, the seasonal worker and the indigenous person.

Services: Largely provided are medical, dental and related services. Also utilized outreach and follow-up services to patient and family. Can purchase services of specialized medical services and hospitalization. Also has a national migrant health referral system. Can provide transportation to medical services and prosthetic devices.

PLAN DE SALUD DEL VALLE, INC.

Contact: Jerry Brasher, Director
Address: 1190 Denver Avenue, Fort Lupton, CO 80621
Telephone: 857-2766

Eligibility Requirements: Will provide health or medical related services to any person. Need not have state residency. Geographic catchment area is northern half of Weld County and Larimer and Morgan Counties. Client pays for services based on amount of income, not to be less than 10% of medical costs. Program more toward serving the migrant worker, the seasonal worker, and the indigenous person.

Services: Largely provided are medical, dental, and related services. Also utilized outreach and follow-up services to patient and family. Can purchase services of specialized medical services and hospitalization. Also has national migrant health referral system. Can provide transportation to medical services and prosthetic devices.

COLORADO MIGRANT COUNCIL

Contact: Jose Herro, Director
Barbara Cambas, Supervisor or Outreach
Address: 115 Main Street, Box 518, LaSalle, CO 80645
Telephone: 284-5523

Eligibility Requirements: 1) Individual must be a migrant or seasonal worker, i.e., 51% or more of the previous years income must have been earned through agricultural occupation, 2) Must have earnings of/or less than the federal definition of "poverty level income".

Services: Beyond the major thrust of migrant child care, emergency food, emergency relief, housing, job development/placement, education, etc., the program can provide for health services and hospitalization through Plan de Salud del Valle, Inc., and East Side Health Center.

LOW VISION SERVICES

Contact: Dr. Robert Siblerud, O.D.
Address: 517 Main Street, Windsor, CO 80550
Telephone: 484-4026

Provides optometric low vision services for individuals who have severe visual loss. Service is private and therefore a fee is charged.

SALVATION ARMY

Contact: Captain Ernest P. Ouellette
Address: 1119 6th Street, Greeley, CO 80631
Telephone: 353-1441

Eligibility Requirements: Individual must be needy.

Services: Can provide eye glasses for needy who cannot afford such including residents as well as transcients.

WELD COUNTY DEPARTMENT OF SOCIAL SECURITY

Contact: Verne Cozens
Address: 1113 10th Avenue, Greeley, CO 80631
Telephone: 353-2262

MEDICARE

Eligibility Requirements: A recipient of other Social Security cash benefit programs. If under 65 years of age, must have been disabled for at least two years, all over 65 are eligible.

Services: There are two parts to this health program which is actually a Federal government contract with private insurance companies. 1) Part A which assists

in payment of necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility or for care in one's home by a home health agency. 2) Part B can help pay for medically necessary doctors services, outpatient hospital services, outpatient physical therapy and speech pathology services, and a number of other medical services and supplies that are not carried under Part A. Not all Medicare recipients receive Part B, which generally covers only 80% of "reasonable charges". Can assist in ophthalmological services including surgery. Will not cover general examinations or eye care. Will assist with internal prosthetic devices and glasses; the latter only after the first cataract surgery.

WELD COUNTY DEPARTMENT OF SOCIAL SERVICES

Contact: Lee Bogart
Address: 313 N. 11th Avenue, Greeley, CO 80631
Telephone: 352-1551

MEDICAID

Eligibility Requirements: Must be over 65 years of age and a recipient of other Social Services programs or meet the income and assets criteria or must be a recipeint of Supplemental Security Income (SSI)*. If over 65 years of age, the maximum income allowable is $196 per month. The SSI recipient is automatically eligible. The second factor considered for eligibility is assest (value of items owned). Beyond standard property exemptions of personal effects, a home, a burial plot, and life insurance of $5,000 or less, the applicant cannot have in excess of $1,000 to qualify, irregardless of possibly meeting the income requirements. If with spouse, the individual may have $2,000 in assets.**

Services: Medicaid can provide hospitalization, intensive care services, transportation for medical purposes, "internal prosthetic devices", office calls, most prescription drugs, and most durable medical goods. Can provide glasses only after the first cataract surgery.

*Supplemental Security Income (SSI) is a program administered under Social Security which provides monthly cash payments for those in financial need who are : 1) 65 years of age or older. 2) Physically and mentally disabled and younger than 65. Payments may be made if the individual is unable to engage in substantial employment and if the impairment is expected to result in death or to last (or has lasted) for twelve months or longer.

**Social Services has a spenddown program designed to allow individuals with other assets or income in excess of maximum to reduce their net income and/or assets to the Supplemental Security Income level. Money must be expended on medical and related bills within a six month period.

WELD COUNTY EYE GLASS PROGRAM

Eligibility Requirements: Must be a recipient of other Social Services programs or

Weld County Eye Glass Program (Continued)

those of Supplemental Security Income (SSI). If a non-recipient, requirements are: 1) 65 years or over with an income not exceeding $196. 2) 60 to 65 years must have an income not exceeding $196 and 35 years residency in the State of Colorado. 3) Under 60 years of age, must be disabled and, a) if eligible for Supplemental Security Income, cannot earn more than $176 per month, b) if ineligible for Supplemental Security Income, having an income not exceeding $155 per month. The assets are also a consideration for eligibility and are the same as for all programs. (See Medicaid Program)**

AID TO THE BLIND-TREATMENT (AB-T)

Eligibility Requirements: Individuals in need of eye surgery and treatment to prevent blindness or restore vision might be provided services under this program. Income and asset basis is standard in determining eligibility (see County Eye Glass Program).

Services: Can assist in meeting expense of hospitalization required for eye condition, surgical fees, travel, care in nursing home during treatment, prescribed drugs, and corrective glasses. This program is unusual in that glasses may be provided to prevent blindness or restore sight, as well as following surgery. Unusual also, is that an optometrist as well as an ophthalmologist can recommend services such as low vision aids.

WELD COUNTY VETERANS SERVICE OFFICE

Contact: Bob Davis
Address: 9th Avenue and 9th Street, Greeley, CO 80631
Telephone: 353-2212, Ext. 268

Eligibility Requirements: For armed service inflicted injuries only.

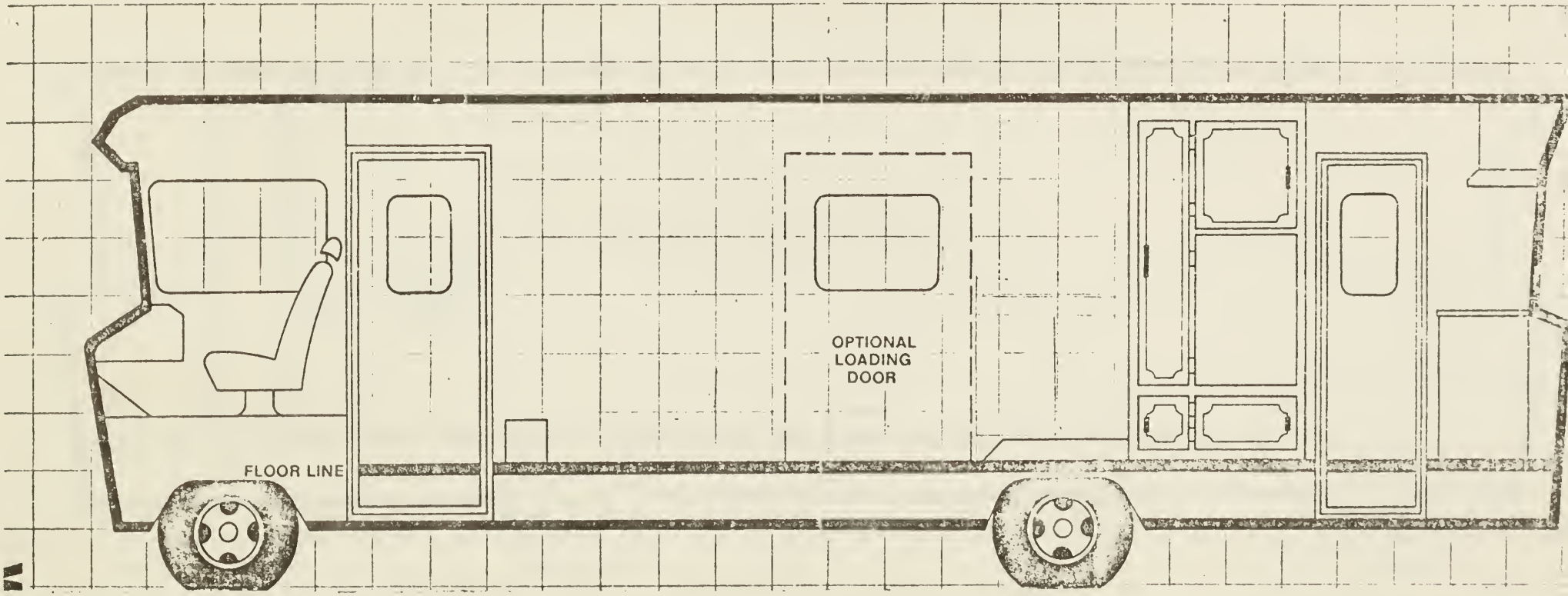
Services: For any malady received while in active armed services, will continue providing needed medical related services.

APPENDIX C

MOBILE UNIT DESIGNS

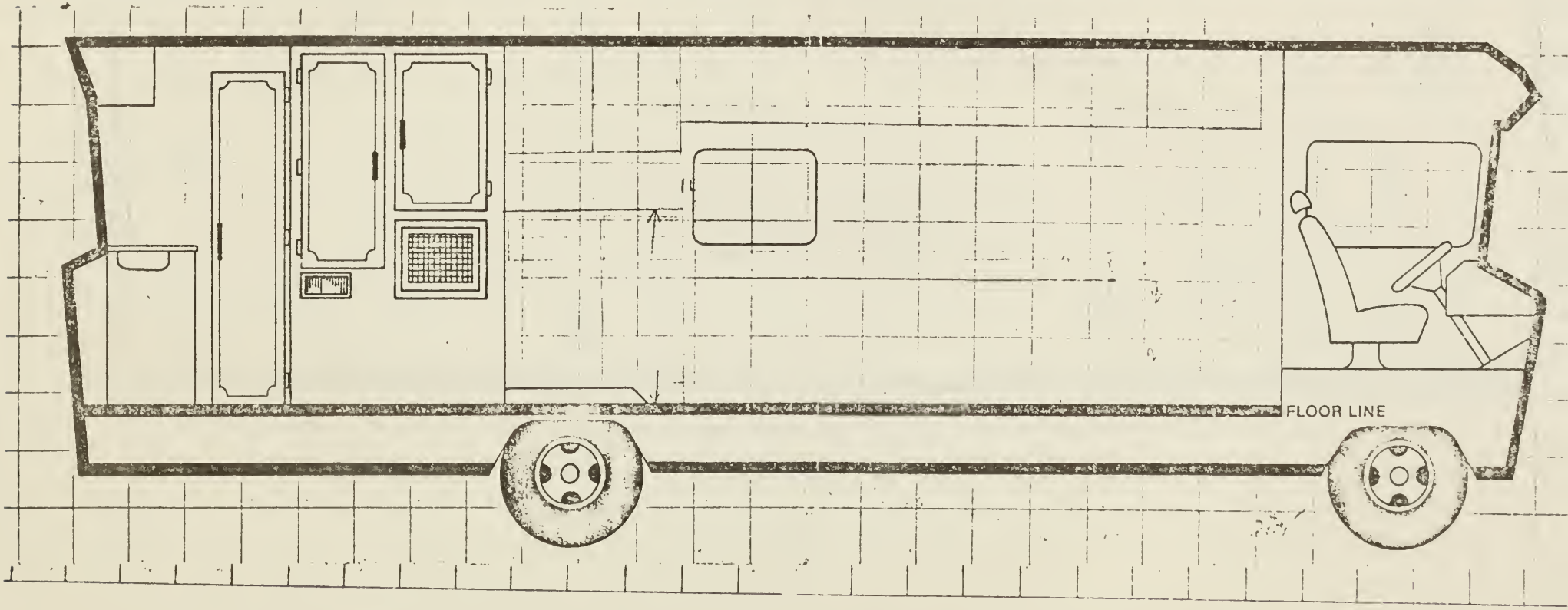
ORIGINAL DESIGN

Left Side



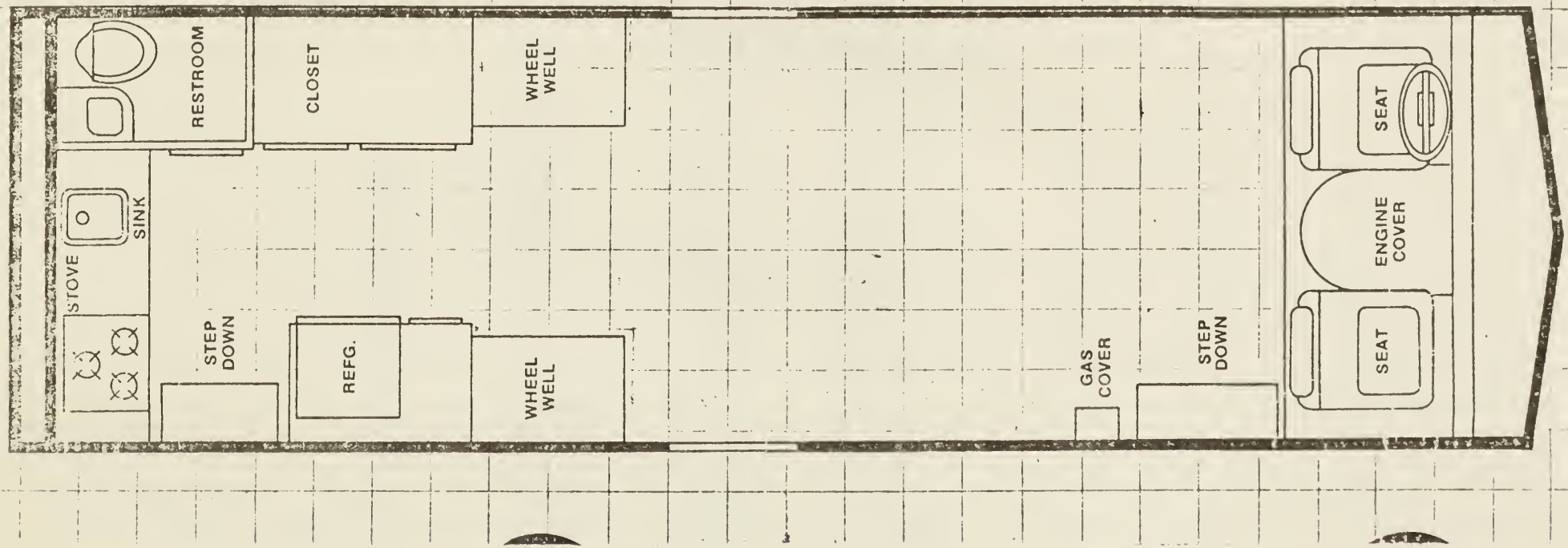
ORIGINAL DESIGN

Right Side



ORIGINAL DESIGN

Floor



MODIFICATION OF EXISTING EQUIPMENT

1-M. Reinforce cabinet #1 above refrigerator and install adjustable shelving equipment and one shelf. Right Side

2-M. Permanently attach 2 dividers in two existing drawers under sink in rear of unit. This will divide interior of drawers into 3 partitions.

3-M. Reinforce existing cabinets 3M and 3Mb and install adjustable shelving equipment. Include 3 shelves for 3Ma and 2 shelves for 3Mb. On Left Side.

December 6, 1974

STANDARD EXPECTATIONS

1. All fronts of cabiness and drawers be dado grooved (approximately 1/4" W X 1/6" D to match Winnebago existing cabinets.

2. Formica tops on all counters match existing Winnebago counter in rear.

3. All hinges and door hardware be of Winnebago design.

4. All paneling, cabinet fronts match Winnebago Model D27MI (approximately Wormy Chestnut).

5. All equipment must be securely fastened to insure safety.

December 6, 1974

L E F T S I D E

Cabinet #1 (Over Wheel Well)

Dimensions: 24" Deep, 34" L, 35½" H (Formica Top)

Design: 4 kitchen sized drawers (approximately 4" H, 15" W, 22" D) 2 cabinets with doors (formica top to match existing)

Particulars:

1. Winnebago door and drawer latches and hinges.
2. Dado grooved front of cabinet
3. Heating duct must be placed on right outside of cabinet.
4. Electircal plug in must be moved to above cabinet space.
5. Adjustable shelf banding with 3 shelves.
6. Dado top and bottom of inside cabinet shelves every 2 inches so that vertical dividers could be placed between shelves.
7. Dado front and back of drawers every 2 inches so as to accomodate ½" vertical dividers. Include 3 ½" drawer dividers.

Cabinet #1 B

Dimensions: 14" D, 34" L, 18" H approximately (to top of window frame)

Particulars:

1. Dado grooved front of cabinet.
2. Winnebago door hinges and latches.
3. Adjustable shelving 1 shelf.

Cabinet #2 B

Dimensions: 14" D, 10' 6" L, 16" H

Particulars:

1. Winnebago latches and hinges.
2. Dadoed groove in door.
3. 5 identical doors, approximate (interior space undivided).
4. Ceiling magnet to hold upswinging doors.
5. Must allow for support posts.
6. Uplifting doors appeoximately 2' L, 14" H.

LEFT SIDE (continued)

Desk #1

Dimensions: 24" D, 7' 6" L, 29½" H
Particulars:

1. 5 drawers of equal size with drop catch
2. Notches for two plug ins through back of counter top (formica top to match existing).
3. Must allow 25" H leg rrom underneath drawers.
4. Drawers approximately 16" W, 3½" H, 22" D.
5. Need support top without taking leg space (such as iron L support)
6. Fasteners on floor under desk to secure 4 folding chairs laid flat.

Desk #2

Dimensions: 36" L, 24" D, 29½" H
Particulars:

1. Formica top to be removable by sliding in a channel forward
2. Formica top 26" H beneath removable top (stationary). Capable of supporting a sewing machine with approximately 25" H leg room.

December 6, 1974

R I G H T S I D E

Cabinet #1 (Identical to left cabinet over wheel well)

Dimensions: 24" D, 34" L, 35½" H

Design: 4 kitchen sized drawers (approximately 4" H, 15" W, 22" D 2 cabinets with doors

Particulars:

1. Winnebago dadoed door, door and drawer latches and hinges.
2. There is no heating duct on this side.
3. Matching yellow formica top.
4. Electrical plug moved above counter top.
5. Adjustable shelf banding with 3 shelves.
6. Dado every 2 inches interior bottom and top of cabinet shelves to allow for possible ¼" vertical dividers to be put between shelves.
7. Dado front and back of drawers every 2 inches so ¼" vertical dividers may be accommodated.
   Include 3 ¼" drawer dividers.

Bench Seat

Dimensions: 5' L, 18" D, 33" H (approximate)
seat approximately 16" H

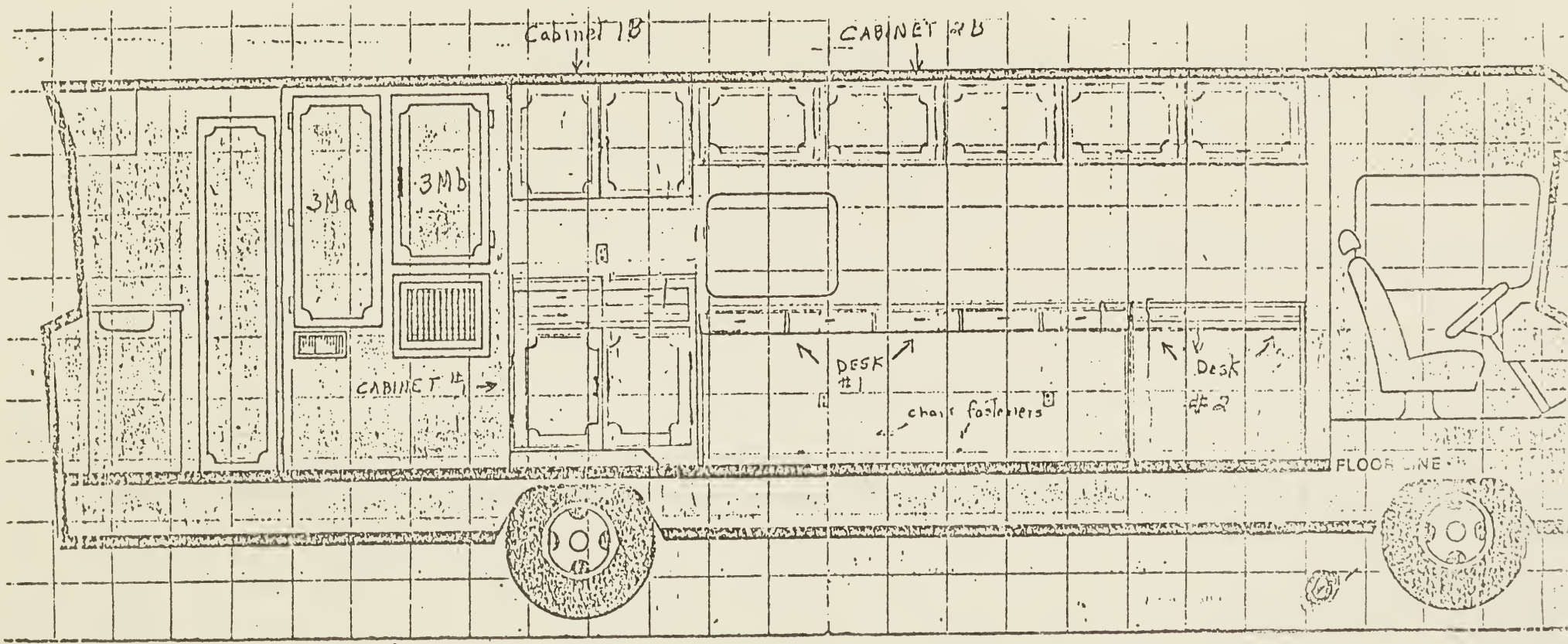
Particulars:

1. 5' cushion on seat and back (attached firmly).
2. 2 drawers that drop lock with Winnebago furnishings and dado front (approximately 10" H, 27" W, 17" D)
3. Seat should be so constructed to allow for future installation of seat belts
4. Dado grooves in drawers every 2 inches in back and front to allow for ¼" vertical dividers. Include 6 vertical dividers.

December 6, 1974

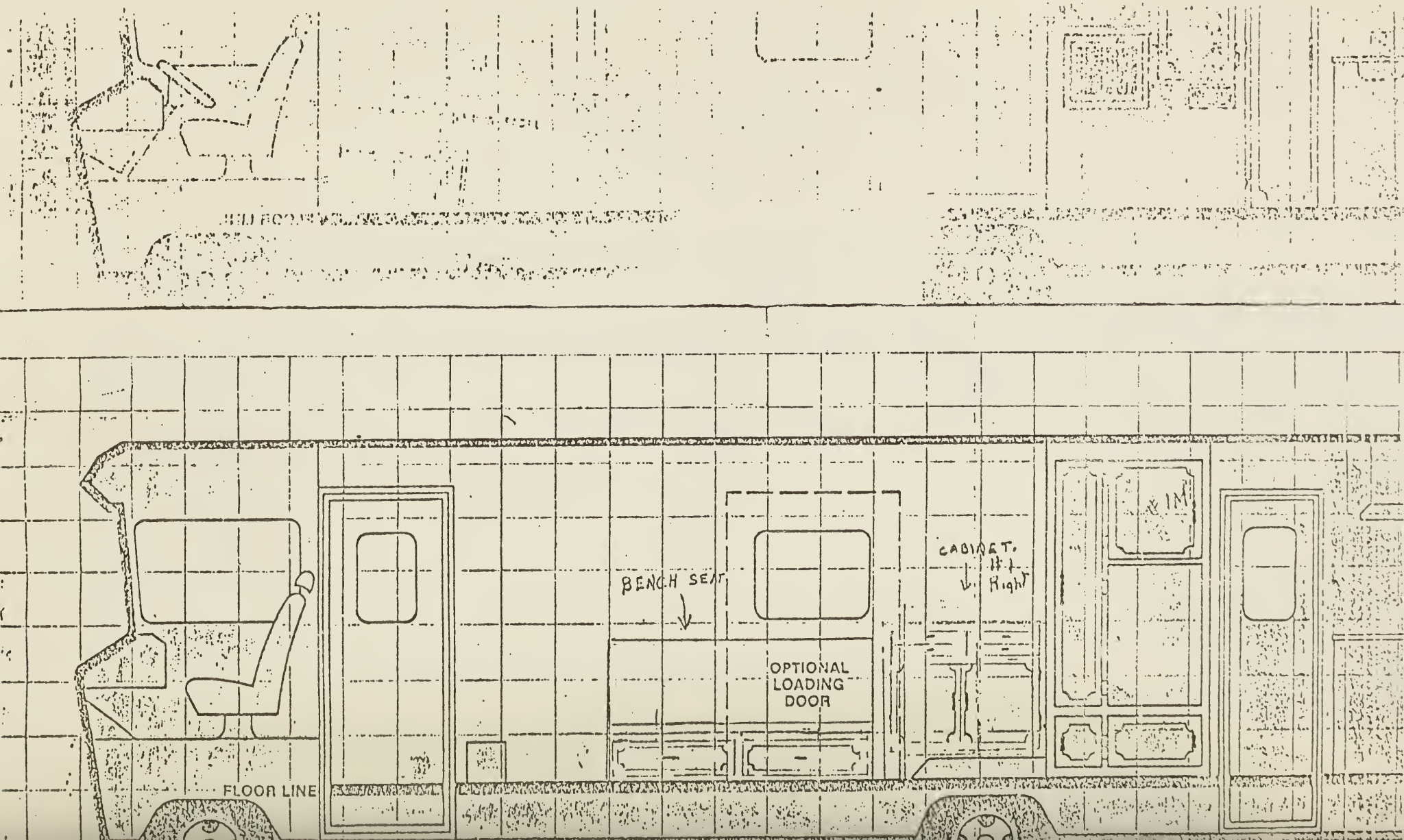
CUSTOM INSTALLED EQUIPMENT

Left Side



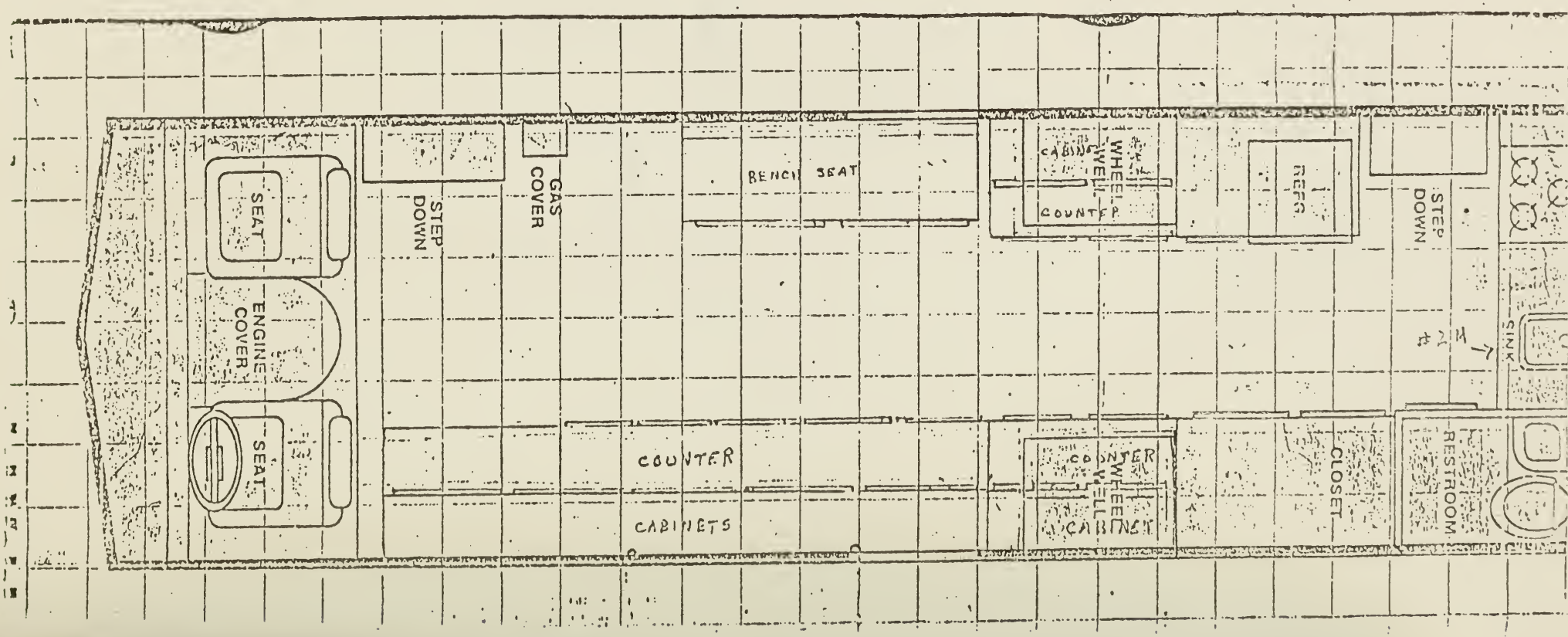
CUSTOM INSTALLED EQUIPMENT

Right Side



CUSTOM INSTALLED EQUIPMENT

Floor



APPENDIX D

IN-SERVICE TRAINING MATERIALS

GUIDELINES FOR IN-SERVICE TO PARA-PROFESSIONALS

HAVING CONTACT WITH

ELDERLY VISUALLY IMPAIRED PERSONS

Contents:

Sample Outline
Recipes for meal preparation - menues
Resource List
List of Material Necessary for In-Service
General Information
Sample Evaluation Sheets

IN-SERVICE

I. Introduction of Project

A. Origin and Objectives

B. Staff and Modes of Giving Services

1. Mobile Unit
2. Home Teaching
3. Teaching Centers
4. Coordination of Other Services and Medical
5. Groups and Counseling
6. Follow-up

C. Counties Served and Schedule for Counties Involved in Staff Development

D. Definition of Legal Blindness and Qualifications

1. Eye Chart and Screening

II. Medical Aspects of Aging and Visual Loss

A. Introduction of Most Common Causes of Blindness

1. Diabetic Retinopathy
2. Cataracts
3. Glaucoma
4. Macular Degeneration

B. Film - "Not Without Sight"

C. Discussion and Questions

III. Psychological Aspects of Blindness

A. Denial

B. Resentment

C. Dependence

D. Adjustment to Blindness

IV. Mobility

A. Introduction

B. Movie - "What To Do When You Meet a Blind Person"

C. Sighted Guide

1. Position - Grip
2. Passageways - Doors
3. Seating
4. Stairs - Ascending and Descending

V. Introduction and Exploration of Vocational Rehabilitation

A. Services for the Visually Impaired

B. Vocational Rehabilitation

C. Question and Answer Session

I. Homemaking

A. Food Preparation

1. Measuring
2. Cutting
3. Pouring
4. AFB Utensils and Labels
5. General Hints

a. Stir from edges of pan into center
b. Use paper towl to cover spills or spot on floor
c. Use wooden spoons
d. Use baster to remove grease from pan
e. Place food to be fried in a pan in a definite order. Turn in same order
f. Tuna ring and muffin pan for eggs
g. Toss salads in plastic bag

B. Use of Major Appliances

1. Manipulation of Dials
2. Use of Burners, Lighting Oven
3. Placing and Removing Food from Oven
4. Using Mitts and Tongs
5. Using Timer

C. Eating Skills

1. Exploration of Place Setting
2. Orientation to Contents of Plate
3. Cutting Meat - Fork or Knife
4. Buttering Bread/Spreading
5. Using Salt and Pepper
6. Sugar and Cream in Coffee
7. General Hints
8. Using Bread as Pusher or Pushing into Mashed Potatoes

II. Meal Preparation

III. Lunch and Clean-up

IV. Mobility

A. Protective Techniques

1. Lower Body
2. Upper Body
3. Modified Forearm
4. Trailing

B. Orientation - Familiarization Techniques

1. Orientation
2. Squaring Off
3. Alignment
4. Room Familiarization
5. Search Techniques
6. Explanation of Canes
7. Explanation of Dog Guides

C. Social Graces

1. Shaking Hands
2. Physical and Verbal Contact

D. Practice and Participation Under Blindfold

V. Personal Management

A. Clothing - Labeling, Mending, Organization for Laundry and Grooming

B. Money Identification and Check Guides

C. Telling Time

VI. Communication

A. Importance of Braille, Typing, Large Print, Handwriting (Guides)

B. TBM

C. Telephone

VII. Activities Under Blindfold

A. Checkers

B. Sewing - Hand and Machine

C. Dialing Phone

D. Dominoes

E. Telling Time - Setting Watch

F. Puzzles

G. Letter and Check Guides

H. Timer and Watches

Menu:

Spanish Rice or Goulash
Tossed Salad
Rolls and Butter
Cake
Coffee and Tea

Recipe for Spanish Rice

¼ c. uncooked rice
3/4 c. cut up, canned luncheon meat
1 tsp. fat or oil
½ small onion
¼ green pepper, if desired
1 small stalk celery, if desired
1 c. canned or cooked tomatoes

Cook rice and meat in fat or oil in a pan until lightly browned. Chop onion, green pepper and celery. Add to rice. Stir in tomatoes. Cover and boil gently about 25 minutes until rice is tender. Makes 2 servings.

Recipe on page 26 - Cooking for Two

Recipe for Goulash

2 Tbsp. butter or margarine
1 small onion, chopped
1 lb. ground beef
¼ c. chopped green pepper
1 One lb. can stewed tomatoes
1 One lb. can water
1½ c. macaroni
1 tsp. salt
1 tsp. Worchestershire Sauce
Dash pepper

Brown onion and ground beef. Drain off excess fat.

Add green pepper, tomatoes, water, macaroni, and seasonings. Bring to a boil. Reduce heat, cover and simmer 10 minutes. Stir occasionally to prevent sticking.

Supplies Needed:

Electric Skillets
Paring Knives
Cutting Boards
Wooden Spoons
Can Opener
Measuring Cups and Spoons
Serving and Eating Dishes
Mitts
Tongs
Timer
Pitcher and Cream Pitcher
Gas Stove Lighter Flint
Pot Holders
Aprons
Paper Towels and Napkins
Dish Washing Soap
Food, Coffee, Tea
AFB Utensils
Labeling Supplies
Dial Marking Supplies
Salt and Pepper
Clothing Labels
Sewing Supplies
Sewing Machine
Clocks and Watches
Money and Guides for Checks, Letters, etc.
Braille Page, Book, and Brailler
Slate and Stylus
Abacus
TBM, Record and Christian Braille Record, TBM Catalogues
Telephone and Dial
Games from AFB
Large Print Cards, Crochet, Crafts
Lenses and Vision Aids
Bold Line Paper, Felt Tip Pens
Homemaking Manuals, Cookbooks, AFB Catalogues
Large Print Cook Book
Projector, Screen, Reel, Movies
Cane and Distance Lenses
Eye Chart
Mobile Unit or Picture
Program Description
Resource List
Referral Forms
Recipe for Meal Preparation
Evaluation Forms
Coins and Bills for Demonstration
Make-up, Toothpaste and Brush, Shaver

General Information

Group Size:

A. 16 - 20 participants is a good group

B. 4 - 5 in a group for cooking and meal preparation is maximum

Sessions:

A. Meal preparation should be part of a whole day session

B. Remaining skills can be one whole day or two part day sessions

Time:

A. 45 - 60 minutes is adequate for any session except meal preparation and perhaps mobility. Allow for coffee breaks and discussion time.

B. Allow time for participants to use aids and appliances, games, etc. Encourage use under the blindfold, but do not insist.

Other Suggestions:

A. Invite volunteers, family members, clients, or others who would also have contact with in-service participants.

B. Showing snap shots or slides of previous, similar in-service sessions might put participants at ease.

C. Try to provide an outline for each participant.

D. Get names, addresses and positions of all participants, including any administrators or supervisors.

E. Try to use a facility with wide open space, chairs, steps and doorways for mobility participation. Kitchen is also necessary.

F. Introduce everyone and use their names so they understand the importance of addressing a blind person so that he knows you are speaking to him.

SERVICES FOR THE OLDER VISUALLY IMPAIRED

2662-C 11th Avenue

Greeley, Colorado 80631

In-Service Training

Short Term Evaluation

(Your comments would be greatly appreciated)

1. Do you think you will feel more confortable around a blind person as a result of this in-service? Yes___ No___

2. Were the films beneficial to you? Yes___ No___

3. Do you feel your questions were answered satisfactorily? Yes___ No___

4. Do you feel that sufficient time was allowed for demonstration and practice of techniques? Yes___ No___

5. Do you feel that your blindfold experience was worthwhile? Yes___ No___

6. Did you learn more from demonstrations or actual practice?

7. What additional information would you like to see included?

8. What would you like to see deleted?

Comments:

SERVICES TO OLDER VISUALLY IMPAIRED PERSONS

Long Term Evaluation

of

In-Service Training Program

1. Has in-service been helpful to you in dealing with a blind person in the area of:

   Homemaking Yes___ No___

   Mobility Yes___ No___

   Comments:

2. Do you feel more at ease and confident around a blind person as a result of the in-service?

   Yes___ No___

   Comments:

3. Do you feel confident in teaching these skills to your clients and/or other homemakers?

   Yes___ No___

   Comments:

4. Would you please explain what you have been able to apply from the training program?

5. What would you like to see added to future in-service training programs?

A MULTIDICIPLINARY APPROACH IN WORKING WITH THE AGING VISUALLY IMPAIRED

"A Practical Soluntion Workshop"

A workshop for all organizations working with older persons with emphasis on the concomitant disabilities that frequent the aging.

Presented Thursday and Friday, January 6 & 7, 1977, at the Holiday Inn, 609 8th Avenue, Greeley, THE RED BARON ROOM.

Your attendance would be appreciated.

There will be NO registration fee.

WORKSHOP SPONSORED BY:

American Foundation for the Blind

Colorado State Services for the Visually Impaired

Colorado State University

University of Northern Colorado

January 6, 1977

8^{00}	- 9^{00}	Registration
9^{00}	- 9^{15}	Greeting - Mr. Kenneth Hutcheson, Administrator, Services for the Visually Impaired
9^{15}	- 9^{30}	An Overview of Services for the Visually Impaired - Mr. Ed Murray, Regional Representative, American Foundation for the Blind
9^{30}	- 10^{30}	Interaction with the Older Visually Handicapped for Better Communication - Dr. Grace Napier, Professor of Special Education, University of Northern Colorado
10^{30}	- 11^{00}	Coffee Break
11^{00}	- 12^{00}	Hearing Impairment Among Aging Persons or "I Can Hear You, But Can't Understand What You're Saying" - Dr. Raymond Hull, Chairperson, Department of Communication Disorders, University of Northern Colorado
12^{00}	- 1^{30}	Lunch
1^{30}	- 2^{30}	Speech and Language Characteristics of the Older Stroke Victim - Dr. Terra Lynn Walters, Assistant Professor, Department of Communication Disorders, University of Northern Colorado
2^{30}	- 3^{00}	Coping Skills for Independent Living - Mrs. Julia Judson, Lecturer, Department of Occupational Therapy, Colorado State University
3^{00}	- 4^{00}	"When the Ayes Don't Have It" - Mrs. Elizabeth P. Wirick, R.D., Associate Professor, Department

January 7, 1977

8^{30}	- 10^{00}	Panel discussion dealing with rehabilitative aspects of the older multi-disabled person Moderator - Mr. Ron Landwehr, Supervisor Elderly Blind Proj
10^{00}	- 10^{15}	Coffee Break
10^{15}	- 11^{30}	Group problem solv
11^{30}	- 12^{00}	Panel input and feedback from grou
12^{00}	- 12^{15}	Wrap up and worksh assessment

SERVICES FOR THE OLDER VISUALLY IMPAIRED

2662-C 11th Avenue

Greeley, Colorado 80631

356-9393

WORKSHOP EVALUATION

Multidisciplinary Approach in Working
with Older Blind Persons Workshop

How would you rate the workshop? Please circle:

Excellent Good Fair Poor

Was the information presented applicable to your field of specialization ?

Yes No

What were the more useful aspects of the program? (Please comment) _____

_____

_____

_____

What additional agenda would be beneficial for you? _____

_____

_____

_____

What suggestions would you have for a future workshop? _____

_____

_____

_____

Name _____ Date _____

Agency or Organization _____

CASE HISTORY

Mrs. Smith is a 70 year old, married, oft times sullen woman who for her entire life has resided in Jamestown, Colorado. She and her husband moved into the low cost housing project, primarily because of her health. Her primary disability has been the residual effects of a stroke, which developed four years ago while being hospitalized for diabetes milletus. This has resulted in visual discrimination of hand movement only, limitations in walking and all physical exertion and movement. Her speech is affected by delays and at times being unable to say what she desires. Although generally complaining about almost everything, the primary complaints are the bland foods she must eat, the inability to see, constant swelling of the ankles, and shortness of breath.

Mr. Smith has religiously cared for his wife in almost every aspect of daily living--personal care and grooming, supporting her in walking, cooking and housekeeping and cleaning. Obviously, he finds it more convenient to perform all these tasks and even communicate for her. Medical advice is that areas of physical exertion need be avoided, but realistically ambulatory activities need to be carefully gauged especially for her own safety. Although Mrs. Smith eternally complains, she does voice that she would like to do almost everything for herself, but what is, "is" by the will of someone greater than herself. She is definitely a person shelled in the fondness of past memories, its fullness--the family she raised, the friends that once were, the church activities--longing wolefully to dematerialize in the face of looming disadvantages of "being a partial human being".

CASE HISTORY

Mr. Davis is an 80 year old, extremely mentally alert, widower residing in Golden Love Nursing Home in Aurora, Colorado. His only professed goal in life is to live away from the "strange old people" he sees daily--to live by himself. His daughter seems to be the primary person to get him admitted seven years ago. History indicates that his wife died one year prior. For a year, he lived with his daughter and family. The daughter depicts the event as a nightmare--"a father who constantly griped, expecting the family to wait on him hand and foot, incessantly chain-smoking cigarettes, burning holes in his clothes, furniture, and carpet." In fact, the last straw leading to his admission to the nursing home was catching the bed on fire with a cigarette.

The daughter has expressed undying support if her father could live independently. She states, "there is no worldly reason why he can't live alone if he would just be responsible for himself." Seems that is always been the problem, he once tried to live alone. It lasted one month. His lack of personal care, housekeeping, nutrition, and neighbor complaints brought him right back to the nursing home where his continual complaints are ever-present.

Innumerable times the staff have tried to involve him in activities to no avail. On discussion with the director of nursing, Mr. Davis is seen as a very blind person (actually no residual vision) who does nothing but sit and complain about the food, the fellow residents, the staff, and tell about how he is going to again live with his daughter. He listens poorly and seldom responds to questions--in fact, when he does, most predictably, he responds to it's none of your business. The administrator confirms the only reason he must stay in the home are his blindness and lack of responsibility and reassures that their policy is appropriate placements of residents in his nursing home. He intimates that if he or his staff can be helpful in assisting Mr. Davis in becoming more happy and active, please make the request.

CASE HISTORY

Mrs. Diaz is an 86 year old, meek, very quiet spoken widow who lives within four walls of her 8 X 8 room in Great Mansions Room and Boarding Home. Food is brought to Mrs. Diaz--cereal at nine a.m., a sandwich and soup for lunch and dinner. Previsouly, Mrs. Diaz was in a nursing home, but left because they "made" her get out of her room. The family then placed her in Great Mansions, where her only need to leave her room is to go to the restroom which she does so adeptly, yet slowly in spite of total visual loss. She has shown fantastic ability to perform other basic tasks--eating from her bowl, dressing herself, playing the radio, and generally manuevering about her room and locating whatever she desires. Otherwise, she will travel nowhere. Her only meainingful conversations are her daughter's daily visits, being otherwise incommunicado with fellow residents. She has comfortably become undoubtedly the product of other people's decisions and assistance, especially her daughter who most responsively knows everything that is best for her mother.

She has a severe urinary tract infection which has errupted into a serious tumor, limiting all walking activities. She also has an unchecked hearing deficit, notable confusion in thoughts, and has never had her eyes examined, all of which are attributed to her fear of doctors, a wish respected by her daughter.

The daughter has decided to have her mother placed in your nursing home. As you are in charge of admissions to Cortez' Nursing Home, it is your job to identify Mrs. Diaz' pre-admission needs and develop a plan for the next staff meeting on new admissions. The plan must include positing timely sequential objectives for Mrs. Diaz, including meaningful inclusion of the resident's family.

CASE HISTORY

Mr. Brown is a 55 year old white male who resides with his wife in Walden, Colorado. He and his wife have raised eight children, all of whom have married and relocated throughout the nation.

Mr. and Mrs. Brown are presently receiving $160 per month from Public Assistance. Innumberable bills are owed, repossessions have taken place on most of their furniture. Due to immense past telephone bills, they do not have and cannot obtain a telephone.

Mr. Brown has finger counting at five feet corrected vision in both eyes as a result of an automobile accident thirty-five years ago resulting in optic nerve damage. He was last checked by an ophthalmologist seven years ago. He has never worked and presently dwindles away the hours sleeping and watching television. Local agencies have invested considerable time in the past to motivate him to no avail, thus have primarily given up.

A current medical report reveals that Mr. Brown has been a heavy smoker, and has a chronic cough and an eczematory erruption of both ankles. He has a great deal of weight loss, but reportedly has a good appetite and eats all foods. Years ago, he had a chronic problem of locked bowels. All of the physical symptoms have been ruled out as possible tuberculosis. The doctor noted that he seemed to, at times, tune in and out of the conversation.

Mrs. Brown is 53 years old and has a history of complaint of a lower back pain which radiates to the hips and legs and extremely abscessed teeth. She personally contributes her unkept home, piles of dirty dishes, irregularity of preparing meals, and innumerable hours of sitting to her pain. Yet, she obviously, in discussion, lacks the interest and implementation of good home, budget, and nutrition management.

As a married couple, they belong to no social groups, have no friends, very rarely leave home and have no transportation.

Lately, Mr. Brown has stated he wants to be more active and wants you to assist him. He is tired of sitting around, yet you know however, that an orientation and mobility instructor has been working with him. On calling the instructor, you will find that Mr. Brown's progress has been very slow. The orientation and mobility instructor had diligently worked with Mr. Brown to increase his orientation and mobility to surroundings outside his home. He seems to constantly forget environmental cues, and where he has been and where he is going as well as a constant equilibrium problem that presents itself as a dull sense of unsteadiness. Also notable, is an excessive lack of manual and motor dexterity which has contributed to problems in mobility.

He is your client.

OF COLORADO
D. LAMM

DEPARTMENT OF REGULATORY AGENCIES
BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS
136 STATE SERVICES BUILDING • 1525 SHERMAN STREET
DENVER, COLORADO 80203 • TELEPHONE 303-892-2050

RECEIVED
DEC 29 1976

MEMORANDUM

TO: Ronald A. Landwehr

FROM: Suzy Schwartz, Secretary to the Board

DATE: December 27, 1976

SUBJECT: Your Inquiry Regarding Continuing Education Credit

COURSE: A Multidisciplinary Approach in Working with the Aging Visually Impaired

Thank you for your inquiry regarding continuing education. After review and consideration the Education Committee has decided:

_____ 1. We need more information regarding:

_____ a) the sponsor

_____ b) the faculty

_____ c) the classroom hours

_____ d) the subjects covered

XXX 2. Your request will be approved for 9 hours of "A" credit for classroom instruction when you supply us with certification of satisfactory completion.

_____ 3. Your request will be approved for _____ hours of "B" credit for community services when you supply us with certification of satisfactory completion.

_____ 4. Your request for credit has been disapproved because the material is not sufficiently relevant to the Guidelines published by the Board.

_____ 5. Your request for credit has been disapproved because the activity appears to be more "in-service" in nature and not generally applicable.

_____ 6. Other: _____

_____

_____

APPENDIX E

FORMS UTILIZED BY PROJECT STAFF

DIVISION OF REHABILITATION
Services for the Blind
CLIENT NEEDS ASSESSMENT

NEEDS	SATISFACTION RATING 1	2	3	4	CLIENT COMMENTS
Orientation & Mobility Techniques					
Cooking					
Sewing					
Laundering					
Housecleaning					
Personal Care					
Personal Management					

NEEDS	SATISFACTION RATING				CLIENT COMMENTS
	1	2	3	4	
Eating Management					
Reading & Writing					
Listening Activities					
Oral Communication					
Hobbies, arts, crafts, etc.					
Social Activities					
Housing Satisfaction					

NEEDS	SATISFACTION RATING				CLIENT COMMENTS
	1	2	3	4	
Personal competence					
Health					
Financial Satisfaction					
Vocational Pursuit Incl. Volunteer					

ers' Impressions & Recommendations

erviewer's Impressions & Recommendations

se back of sheet if more space is required.

Interviewer

GUIDELINES FOR CLIENT NEEDS REPORT

1. Orientation & Mobility Techniques - The clients ability to orient self, indoor and outdoor travel techniques, knowledge of mobility aids, and sensory skills.

2. Cooking - Use of appliances, procedures, preparation, organization, etc.

3. Sewing - Manual and use of machine.

4. Laundering - Equipment and activities.

5. Housecleaning - Use of cleaning tools, solutions, and activities.

6. Personal Care - Grooming and personal hygiene.

7. Personal Management - Handling money, marking personal items, telling time, shaking hands, personal care, and management activities.

8. Eating Management - Eating habits and skills.

9. Reading and Writing - Use of residual vision, braille, low vision reading, typewriting, handwriting, etc.

10. Listening Activities - Use of memory, talking books, recorders, radio, TV, etc.

11. Oral Communication - Includes mannerisms of speech, posture, voice, facial expression, hand gestures, telephone, etc.

12. Hobbies, arts, crafts - Includes type of activity, skills and tools in performing such.

13. Social Activities - Includes quality and quantity of family interaction, peer interaction and relative satisfaction and capabilities.

14. Housing Satisfaction - Kind of housing, length of stay, likes and dislikes of housing situation.

15. Personal Competence - Assurance or lack of assurance in self, self planning, self-determination, and direction.

16. Health - Perception of aspects of general health for past few years and any change, cause and limitations, physical or psychological.

17. Financial Satisfaction - Necessities of income sufficiency for needs and "extras", any changes in finances as compared to the near past and its implication.

18. Vocation Pursuit, including volunteer (specify) - Based on financial and activity need. Capacity to perform vocationally in light of present health, ability, age, education, training, etc.

RATING OF ACTIVITY ITEMS:

1). Equivalent to excellent, implying no perceived need for assistance and personal satisfaction.

2). Good, or basically has developed capabilities, but may need some training or assistance.

3). Fair, or has at least a limited amount of satisfaction and/or ability.

4). Poor, or has little satisfaction and/or experience requiring usually considerable training and education.

Notations in comment section are to more clearly explain and define clients answers.

Others' Impressions and Recommendations: Commentation referring to the activities and needs as perceived by important other persons or referral source. Name, address, and phone should be listed.

Interviewer's Impressions and Recommendations: Based entirely on interviewer's judgement of clients response to given items and specification of clients needs, as well as those of other persons.

(Independent living plan developed later on individual needs.)

VISION SCREENING

Client Name _____ Home Address _____

Telephone Number _____ City/State/Zip Code _____

Screening Location _____ Date of Screening _____

Is person under care of eye specialist? Yes _____ No_____

If yes, date of last examination: _____
Name and address of examiner _____

Screening Results

	FIRST	SECOND
Both eyes:	20/	20/
Right eye:	20/	20/
Left eye:	20/	20/

Screened with glasses:

Right eye: Yes____ No____

Left eye: Yes____ No____

Able to screen: Yes____ No____

Symptoms Observed: _____

To be rescreened: Yes____ No____

Date rescreened _____

Disposition

_____ 1. 20/200 Critical line eligibility

_____ 2. Ineligible, referred for further examination

_____ 3. Ineligible, not referred

Remarks: _____

_____
Signature of Examiner

To be filled out from information of a specialist of eye disease or optometrist

	Visual acuity or field	Cause of loss of sight	Age of occurence
Right eye			
Left eye			

Blindness in other members of the family (Give names & relationship): _____

COLORADO DEPARTMENT OF SOCIAL SERVICES
DIVISION OF REHABILITATION

CERTIFICATE OF ELIGIBILITY OR INELIGIBILITY

I hereby certify that_____meets the selection criteria for:

(Check One)

____ Yes ____ No 1. At least 55 years of age.

____ Yes ____ No 2. Of central visual acuity 20/200 or less in the better eye with correcting lenses or of visual acuity, if better that 20/200, limited to a field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than 20 degrees.

____ Yes ____ No 3. By reason of the combination of disability and age, not likely to be accepted for service by the State Rehabilitation agency.

COUNSELOR'S JUDGEMENTAL STATEMENT FOR MEETING OR NOT MEETING CRITERIA:

_____ DATE

_____ SUPERVISOR OR COUNSELOR

(Use reverse side if more room is required for statement)

EVALUATION UNIT SUMMARY
Orientation and Mobility

Client _____ Date of Report _____

Address _____ Evaluation Period _____ No. of Weeks _____

I. INITIAL INFORMATION
- A. Eye Condition:
- B. Age:
- C. Physical or Health Limitations:
- D. Posture and Gait:

	Demonstration of Skills			
	Inadequate	Adequate	Potential For Learning	Recommendations For Training
II. ORIENTATION				
A. Clockwise Turns				
B. Counter-Clockwise Turns				
C. Degree Turns				
1. 360 degrees				
2. 180 degrees				
3. 90 degrees, right & left				
D. Series of Turns				
E. Route Travel				
1. Follows directions				
2. Reverses route				
III. MOBILITY SKILLS				
A. Pre-Cane				
B. Indoor Travel				
C. Indoor Cane Travel				
D. Residential Travel				
E. Semi-Business Travel				
F. Business Travel				
G. Drop-Off Experience				
H. Home Environment				
IV. AUDITORY SKILLS				
A. Discrimination of Sounds				
B. Location of Sound Sources				
C. Utilizing Sound Cues for Direction				

V. NARRATIVE SUMMARY OF SKILLS AND INABILITIES

VI. RECOMMENDATION FOR TRAINING

TRAINING UNIT PROGRESS REPORT
Homemaking, Personal Adjustment and Communications

Client _____ Date of Report _____ Total wks. in Trng. _____

Address _____ Report period _____ Wks. this Report _____

	No. of Lessons	Level of Competency	Summary Statement
Homemaking			
I. PERSONAL CARE			
A. Grooming			
B. Personal hygiene			
II. IDENTIFICATION OF PERSONAL ITEMS			
A. Via touch, smell			
B. Via location			
C. Use of labels, markers			
III. CLEANING			
A. Washing dishes			
B. Cleaning flat surfaces			
C. Use of vacuum			
D. Scrubbing, waxing			
E. Cleaning, wood, upholstery			
F. Making beds			
IV. LAUNDERING			
A. Washing clothes, linens			
B. Use of clothes dryer			
C. Use of clothes line, drying rack			
D. Ironing			
V COOKING			
A. Use of major appliances			
B. Safety procedures			
C. Use of timer			
D. Pouring liquids			
E. Measuring solids & liquids			
F. Cutting, slicing, dicing			
G. Cooking procedures			
1. Frying			
2. Boiling			
3. Baking			
4. Broiling			
5. Roasting			
6. Serving Food			

	No. of Lessons	Level of Competency	Summary Statement
H. Household record keeping			
1. Labeling papers			
2. Maintaining address & telephone no's.			
3. Identifying money			
4. Storing money in wallets			
I. EATING TECHNIQUES			
A. Sitting at table			
B. Exploration of place setting			
C. Orientation to plate contents			
D. Managing salads			
E. Cutting meats			
F. Buttering bread, rolls			
G. Seasoning foods			
H. Pouring cream			
I. Ladling gravy			
J. Managing desserts			
K. Table etiquette			
L. Eating in cafeterias			
M. Ordering Food in restaurants			
Communication			
I. BRAILLE READING			
A. Alphabet and alphabet word signs			
B. Numerals, punctuation, composition signs, whole word signs (single cell)			
C. Whole-&part-word signs, contraction signs, whole word signs			
D. Initial contractions; short-forms, prefixes & suffixes			
E. Punctuation marks as lower signs; whole-word signs; rules for lower word signs; short-forms			
F. Lower part-word signs; rules; short forms			
G. Final signs; proof-reading; rules			
H. Braille composition signs; numeric notations; abbrev.; time, decimals			

	No. of Lessons	Level of Competency	Summary Statement
II. BRAILLE WRITING			
A. Use of braille slate & stylus			
B. Use of braille writer			
C. Accuracy with braille writer			
D. Speed with braille writer			
III. TYPEWRITING			
A. Manipulation of typewriter, setting margins, inserting paper, setting tabular stops			
B. Finger keys			
C. Hand position and general posture			
D. Accuracy in typewriting			
E. Speed in typewriting			
F. Correcting errors			
IV. HANDWRITING			
A. Sign name			
B. Write messages			
C. Use of writing aids, boards			
V. LISTENING SKILLS			
A. Use of talking books			
B. Use of tape recorders			
C. Use of radio & T.V.			
D. Use of human readers			
E. Use of informational sources: (catalogues)			
1. Library of Congress			
2. Recording f/t Blind			
3. American Found.f/t/ Blind			
4. American Printing House			
5. Volunteer recording groups			
VI. ORAL COMMUNICATION			
A. Speaking mannerisms (voice)			
B. Postural mannerisms			
C. Use of facial expressions			
D. Hand gestures, body language			

TRAINING UNIT PROGRESS REPORT
Department: Orientation & Mobility

Client_____ Date of Report_____ Total Wks. in Trng._____

Address_____ Reporting Period_____ Wks. in this Report_____

	No. of Lessons	Competency Level	Summary Statement
I. PRE-CANE SKILLS			
A. Sighted Guide			
B. Seating			
C. Male Social Graces			
D. Hines Break			
E. Upper Hand and Forearm			
F. Lower Hand and Forearm			
G. Trailing Technique			
H. Locating Dropped Objects			
I. Squaring Off			
J. Direction Taking			
K. Room Familiarization			
L. Diagonal Technique			
M. Diagonal Tech. with Guide			
N. Diagonal Tech. with Trailing			
O. Auditory Skills			
II. INTRODUCTION TO CANE			
A. Touch Technique			
B. Touch and Slide			
C. Touch and Drag			
D. Locating Car Door Handles			
E. Exploration of Objects			
F. Touch Tech. & Trailing			
G. 3-Point Shoreline			
H. Ascending Stairs			
I. Descending Stairs			
J. Orientation Skills			
K. Auditory Skills			
III. RESIDENTIAL TRAVEL			
A. Car Familiarization			
B. Grass Shoreline			
C. Maintaining Straight-Line Travel			
D. Locating Intersecting Sidewalks			
E. Straight-Curb St. Crossings			

	No. of Lessons	Competency Level	Summary Statement
F. Rounded Curbs			
G. Blending Curbs			
H. Gen. Block Travel (Orientation)			
I. Knowledge of Grid Pattern			
J. Knowledge of Compass Points			
K. Use of Sun			
L. Perception of Textures and Graidents			
M. Gait and Posture			
N. Reflex Actions			
O. Strength and Stamina			
P. Adherence to Safety Precautions			
Q. Reaction to Sighted Public			
IV. BUSINESS TRAVEL			
A. Stoplight/Crossings			
B. Knowledge of Street Names			
C. Locating Stores, Landmarks			
D. Travel in Congested Areas			
E. Use of Assistance (Guides)			
F. Asking Directions			
G. Travel Inside Stores, Bldgs.			
H. Interaction with People			
I. Use of Public Transportation			
J. Revolving Doors			
K. Escalators			
L. Elevators			
M. Drop-Off Lessons			
V. NARRATIVE SUMMARY			

3-CDR-23

STATE OF COLORADO
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF REHABILITATION
SERVICES FOR THE BLIND

OPHTHALMOLOGICAL CONSULTANTS REVIEW

1. Name of client_____ 2. Age_____

3. Examination report by Dr._____ 4. Date of Exam_____

5. Is the examination report sufficiently complete including fields?

6. Is the client eligible for services from the standpoint of meeting one of the definitions of legal blindness?

7. If not legally blind, but visually impaired, explain:

8. Recommendations for further examinations, treatment, prosthesis, etc.

9. Are any working conditions or physical activities to be avoided because of eye disability other than those imposed by visual loss?

10. Other remarks.

_____ _____
Ophthalmological Consultant Date

CDR-7 (4/74)

COLORADO DEPARTMENT OF SOCIAL SERVICES
DIVISION OF REHABILITATION

RETURN THIS FORM TO:

CONFIDENTIAL

GENERAL MEDICAL EXAMINATION

SECTION I: TO BE FILLED OUT BY APPLICANT AND COUNSELOR BEFORE PHYSICAL EXAMINATION.

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH MO. DAY YR.	SEX M F	RACE CODE	MARITAL STATUS SING MAR WID DIV SEP

ADDRESS	NAME OF COUNT
CITY, STATE AND ZIP CODE	SOC. SEC. NO.
USUAL OCCUPATION AND DESCRIPTION OF LAST JOB.	PRESENT DISABILITY.

NOW UNDER CARE OF PHYSICIAN? ☐ YES ☐ NO	LAST VISIT (DATE)	(NAME AND ADDRESS OF PHYSICIAN)

HAS THE APPLICANT EVER BEEN AFFLICTED WITH ANY OF THE FOLLOWING:

☐ EXCESSIVE FATIGUE	☐ CONVULSIONS OR "FITS"	☐ PERSISTENT COUGH	☐ HEMORRHOIDS
☐ UNUSUAL WEIGHT GAIN OR LOSS	☐ DIFFICULTY WITH THINKING	☐ COUGH PRODUCING BLOOD	☐ DIARRHEA OP CONSTIPATION
☐ FAINTING SPELLS	☐ DIFFICULTY WITH MEMORY	☐ SHORTNESS OF BREATH	☐ BLOOD IN STOOL OR URINE
☐ FEVER AND NIGHT SWEATS	☐ DIFFICULTY WITH VISION	☐ PAIN IN CHEST	☐ PAINFUL OR DIFFICULT URINATION
☐ UNUSUAL IRRITABILITY	☐ DIFFICULTY WITH HEARING	☐ SWOLLEN ANKLES	☐ HERNIA
☐ FREQUENT HEADACHES	☐ TUBERCULOSIS	☐ LOSS OF APPETITE	☐ RHEUMATISM
☐ NERVOUS BREAKDOWN	☐ ASTHMA OR HAY FEVER	☐ FREQUENT INDIGESTION	☐ VARICOSE VEINS OR ULCERS

OPERATIONS

ACCIDENTS

FRACTURES

SERIOUS ILLNESS

COUNSELOR DATE

FOLLOWING SECTIONS TO BE COMPLETED BY EXAMINING PHYSICIAN

SECTION II: PRESENT COMPLAINT AND PAST HISTORY (INCLUDE COMMENTS ON ITEMS CHECKED ABOVE)

SECTION III: LABORATORY FINDINGS

URINALYSIS: SP. G	PH	SUGAR	ALBUMIN	DATE

NAME, DATE AND RESULTS OF OTHER RECENT EXAMS:

SECTION IV

	CHECK IF NORMAL
1. EYES (DISCHARGE, STRABISMUS, PTERYGIUM, PTOSIS, DUNDI, CATARACT, ETC.)	
2. EARS (EVIDENCE OF DEAFNESS, MIDDLE EAR OR MASTOID DISEASE. DRUMS: ABSENT, PERFORATED, DULL, RETRACTED. DISCHARGE)	
3. NOSE (OBSTRUCTION. EVIDENCE OF CHRONIC SINUS INFECTION, POLYPI)	
4. THROAT (TONSILS: ENLARGED, REMOVED)	
5. MOUTH (MISSING TEETH, PYORRHEA, CARIES, ABNORMAL TONGUE OR PALATE)	
6. NECK (THYROID ENLARGEMENT, NODULES, MASSES)	
7. BREASTS (ABNORMAL DISCHARGE, NODULES, TENDERNESS)	
8. LUNGS (CONFORMATION, RESPIRATORY MOVEMENT, BREATH SOUNDS, RALES, DULLNESS)	
9. HEART (ENLARGEMENT, THRILLS, MURMERS, RHYTHM, DYSPNEA, CYANOSIS, EDEMA)	
10. ARTERIES (PERIPHERAL PULSATIONS)	
11. VEINS (VARICOSE: LOCATION, SEVERITY)	
12. ABDOMEN (SCARS, MASSES, PALPABLE LIVER OR SPLEEN, TENDERNESS)	
13. HERNIA (SITE, TYPE, SEVERITY)	
14. GENITALIA.MALE (DISCHARGE, VARIOCELE, HYDROCELE, PROSTATE)	
15. GYNECOLOGICAL (DESCRIBE SIGNIFICANT ABNORMAL CONDITION, SEVERITY AND EXTENT)	
16. ANO.RECTAL (SEVERITY AND EXTENT OF HEMORRHOIDS, PROLAPSE, FISSURES, FISTULA, ETC.)	
17. NERVOUS SYSTEM (GAIT, REFLEXES, SENSATION, PARALYSIS, SPEECH, ETC.)	
18. PSYCHIATRIC (MOOD, ABNORMAL BEHAVIOR, ETC.)	
19. SKIN (LESIONS, SCARS, ABNORMALITIES.EXTENT AND SEVERITY)	
20. ORTHOPEDIC (CONGENITAL OR ACQUIRED IMPAIRMENTS, FEET, BACK, AMPUTATIONS, ETC.)	

HT._____ WT._____

TEMP._____ PULSE_____ BLOOD PRESSURE_____

VISION

DISTANT R_____ L_____ CORR. R_____ L_____

NEAR R_____ L_____ CORR. R_____ L_____

HEARING

R_____ L_____

DESCRIBE ABNORMALITIES IN DETAIL

ATTACH SEPARATE SHEET IF NEEDED

SECTION V

1. DESCRIPTION OF MAJOR IMPAIRMENTS (THIS SHOULD GIVE THE COUNSELOR A GOOD PICTURE OF THE PATIENT'S LIMITATIONS WHICH WILL AFFECT EMPLOYMENT)

A. ONSET AND CAUSE

B. NATURE AND EXTENT OF RESIDUALS

C. DIAGNOSIS

D. PROGNOSIS

E. CHARACTERISTICS OF MAJOR IMPAIRMENT (CHECK APPROPRIATE TERMS)

☐ PERMANENT ☐ STABLE ☐ RAPIDLY PROGRESSIVE

☐ TEMPORARY ☐ SLOWLY PROGRESSIVE ☐ IMPROVING

F. CAN THE MAJOR IMPAIRMENT BE: (CHECK APPROPRIATE BOX)

1. REMOVED BY TREATMENT ☐ YES ☐ NO 2. SUBSTANTIALLY REDUCED BY TREATMENT ☐ YES ☐ NO

G. PHYSICAL CAPACITIES: (UNDER "PHYSICAL ACTIVITIES" AND "WORKING CONDITIONS" USE SYMBOLS AS FOLLOWS:

(✓) NO LIMITATIONS (X) LIMITATION (O) TO BE AVOIDED

PHYSICAL ACTIVITIES: WALKING_____ STANDING_____ STOOPING_____ KNEELING_____

LIFTING_____ REACHING_____ PUSHING_____ PULLING_____

OTHER: SPECIFY_____

WORKING CONDITIONS: OUTSIDE_____ INSIDE_____ HUMID_____ DRY_____ DUSTY_____ SUDDEN TEMP. CHANGES_____

OTHER: SPECIFY_____

SECTION VI: RECOMMENDATIONS (CHECK OR COMPLETE AS INDICATED)

ADDITIONAL EXAMINATIONS (BLOOD, X-RAY, EKG, EEG)

MEDICAL TREATMENT (MEDICATION, SURGERY, THERAPY)

I DECLARE THAT THIS PATIENT HAS BEEN EXAMINED BY ME AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, THIS REPORT IS TRUE, CORRECT AND COMPLETE, AND SERVICE IS PROVIDED WITHOUT DISCRIMINATION ON THE GROUNDS OF RACE, COLOR, RELIGION, SEX, OR NATIONAL ORIGIN.

PRINT NAME OF ATTENDING PHYSICIAN

DATE OF EXAMINATION (MONTH, DAY, YEAR)

SIGNATURE OF ATTENDING PHYSICIAN

ADDRESS

DIVISION OF REHABILITATION

Services for the Blind
Low Vision Evaluation

Date _____

Client's Name _____

Client's Home Address _____

Client's Eye Condition with Best Correction _____

_____

Attached Doctor's Report

I. GENERAL INFORMATION

A. Age _____

B. Sex _____

II. DIAGNOSIS

A. Onset and Prognosis _____

_____

B. Visual acuity and field of vision _____

_____

C. Additional handicaps or limitations _____

_____

III. TYPE OF AIDS USED BY CLIENT

A. Cane _____

B. Spectacles _____

C. Low Vision Aids _____

D. No Aids _____

IV. OBSERVATIONS OF CLIENT'S PERFORMANCE
QUESTIONNAIRE OF CLIENT'S NEEDS AND SELF-INDUCED LIMITATIONS

A. Can the client read? Yes _____ No _____

If yes,
1. Large print Yes _____ No _____
2. Newspaper Yes ___ No _____
3. Magazines Yes ___ No _____

B. Does the client watch television? Yes _____ No _____

If yes,
at what distance _____

C. Can the Client perform daily tasks with residual vision?
Yes _____ No _____

1. Self care skills Yes _____ No _____
2. Home Management Yes _____ No _____

D. Does the client utilize public transportation Yes _____ No _____

E. What fears (if any) does the client feel? Movement, confidence and judgment or what _____
_____

V. LOW VISION TRAVEL EVALUATION

A. Area of travel
1. Residential _____
2. Semi-business _____
3. Business _____

B. Light conditions and time of day _____
_____

C. Does the client show confidence and safety? Yes _____ No _____

D. Is the client able to walk in a straight line. Yes _____ No _____

E. Is the client able to see steps and curbs? Yes _____ No _____

If yes,
at what distance _____

F. Can the client recognize areas of contrast? Yes ____ No_____

1. Doors _____
2. Sidewalks ____
3. Streets _____
4. Buildings _____

G. Does the Client use scanning movements? Yes _____ No _____

If yes,
are they ungainly? Yes _____ No _____

H. Is the client able to avoid collisions with immovable objects? Yes _____ No _____

Is the client able to avoid collisions with pedestrians who are moving? Yes _____ No _____

I. Is the client able to recognize unidentifiable objects by comparision of gross distinctive features? Yes _____ No _____

Cars in a parking lot? Yes _____ No _____

J. Can the client sort out logical alternatives by utilizing environmental clues in choosing these alternatives? Yes _____ No _____

K. Is the client able to process information from a wide area in minimal time? Yes _____ No _____

L. Can the client step from an area light adapted and/or areas of reduced illumination and recognize objects by size, shape, brightness and contrast? Yes _____ No _____

Viewing time _____ Shaded areas, benches, signs, etc...

M. Is the client able to read street signs? Yes _____ No _____

If yes,
at what distance _____

what is the preferred distance _____

N. Is the client able to locate overhead signs? Yes _____ No _____

Can he/she read them? Yes _____ No _____

If yes,
at what preferred distance _____

O. Is the client able to see traffic lights? Yes _____ No _____

If yes,
at what distance _____

P. Is the client able to predict speeds of moving objects? Yes ___
No _____

1. Pedestrians _____
2. Cars _____

Q. Is the client able to predict the direction or path of moving objects? Yes _____ No _____

1. Pedestrians _____
2. Cars _____

R. Can the client cross streets safely? Yes _____ No _____
with traffic lights? Yes _____ No _____

S. Given directions, can the client locate specific objectives?
Yes _____ No _____

If no,
discuss problems _____
_____
_____
_____

T. Does the client shy away from or utilize areas of glare? Yes ____
No _____

U. Does the client utilize his other senses to compensate for visual restrictions? Yes _____ No _____